the Canadian Nurse

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OCTOBER 1963

CHANGES IN NURSING EDUCATION IN SASKATCHEWAN

COLLECTIVE BARGAINING

INVITATION TO NEWFOUNDLAND

BASIC QUALITIES OF A GOOD NURSE

STRABISMUS

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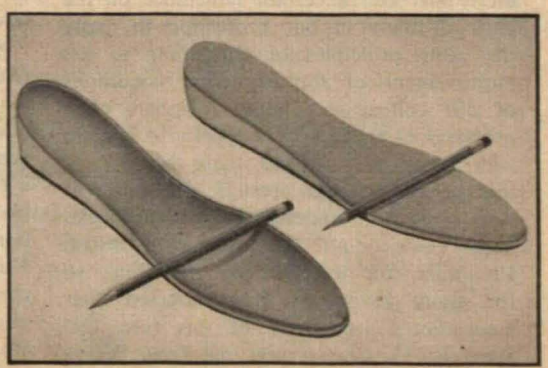

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Between Ourselves

A long stride forward, in the pursuit of improved patterns and methods in nursing education, was taken by the membership of the Saskatchewan Registered Nurses' Association at their 1963 convention. After several years of intensive study, innumerable committee meetings, representations to governmental and other bodies, and conferences with many individuals, the master plan was approved by the membership. LINDA LONG, who is the advisor to schools of nursing in the S.R.N.A. organization, has traced the course of these developments and outlined the plans for the future in this month's lead article.

* * *

The use of collective bargaining machinery is a very familiar factor in the settlement of disputes between the working man and his employer over hours of work, wages, pensions and many other phases of working conditions. Though these same aspects of employment are matters of considerable concern to thousands of nurses, there has been a certain reluctance on the part of many in our profession to apply the same principles of bargaining to the improvement of the economic conditions of our colleagues. Should members of a professional group seek authority to bargain with employers? Would there be risk of loss of professional prestige and status if such steps were undertaken by a provincial nurses' association? The nurses in British Columbia, for instance, do not think so for many years ago they endorsed their association's acceptance of this role. DR. JOHN H. G. CRISPO lays the facts clearly on the line in his article "Collective Bargaining and the Professional." However, he has pointed out that any observations regarding collective bargaining should be taken as tentative since the research has yet to be completed.

* * *

Incidentally, the Economic Welfare Division of the International Council of Nurses, established at the Congress held in 1961, has been authorized to expand the scope of its activities "particularly toward assisting national nurses' associations to take a more active part in the negotiation of economic conditions for nurses while maintaining the integrity and autonomy of the nursing profession."

* * *

While not specifically a series of articles in terms of our usual pattern of presenting considerable material on one phase of illness, this month's major topic could be labelled "The Child." Hidden in the stories of Johnny, of Jennifer are a considerable number of important nursing pointers that we sometimes overlook. We hope that you will find information of value in all of the articles. It is there.

* * *

Your attention is drawn to the fact that the Canadian Nurses' Association is already developing plans for tours following the 32nd biennial meeting in St. John's, Newfoundland in June of next year. If you would like to have some tour or tours arranged to *precede* the convention as well, please write to National Office, 74 Stanley Avenue, Ottawa, very soon.

Speaking of next year's convention, do read the reproduction of JEAN LEWIS's formal invitation that she presented to the audience in Vancouver last year. And while you are reading it, go over in your mind a few of the reasons why you should begin planning to send in your advance registration form just as soon as you receive your November issue (we are putting it in the centre of that number so you can't possibly miss it). Here are a couple of sound reasons why you should mull this matter over:

1. You have never attended a CNA convention. (How do we know? With some 70,000 members in the CNA, fewer than 1,000 were registered for the full week in Vancouver! Hence, about 69,000 of you weren't there).

2. You have never been in Newfoundland. Did you know that the most easterly prominences of the Appalachian Mountain chain divide the island into densely wooded areas on the western side, muskeg covered rocky prominences on the eastern? For

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE *nor of the Canadian Nurses' Association.*

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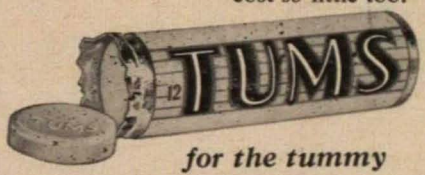

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STAMFORD, CONNECTICUT

Random Comments

Dear Editor:

I have just finished reading Miss Pelley's article "Problems ! Dilemmas ! Questions !" (May 1963). I am so enthused to hear that someone is thinking clearly about nursing, that I feel compelled to add a few of my own pertinent thoughts concerning the future of our profession.

I am appalled to learn that we are thinking of educating two groups of professional nurses — as suggested by Miss Katherine MacLaggan in the article "Nursing Education, the Chief Topic in Ottawa." If we are to maintain a profession, I believe it imperative that basically all our members be educated in a similar manner. We cannot have two meaningful RN's. We cannot exclude one group from postgraduate education.

In the medical profession, the MD is the basic degree given to all doctors. Postgraduate courses are then open to all who qualify. Should we not adopt this proven pattern for the nursing profession? If we persist in this dual grouping, we will end up with so many levels that the "RN" will be meaningless.

In our efforts to improve standards of nursing education, let us not become too snobbish and insist that higher education must necessarily mean university education. Surely our approved nursing schools in hospitals have a good deal more to offer than the barren walls of a university for basic nursing education. If nursing is appreciation and response to all life situations then it cannot be divorced from the total care of the patient. What better teaching opportunities exist than those found in our large hospitals, with their well-qualified teaching staffs ? Where else can the young student derive the stimulus, the discipline, the awareness, the decision that nursing demands in the process of learning ! Let us, of course, recognize that postgraduate education is required for many nursing positions, but let us assure our student nurses that their RN will be a passport to all postgraduate courses.

It is time for us to be realistic. For the life of me, I cannot see why any bright girl who has completed high school, would spend two academic years in a university, plus three years (33 months) in a nursing

school for a BSN or equivalent when she could obtain a BSc in only three academic years (18 months) and immediately qualify for a higher salary.

Certainly the time is long overdue for many decisions in nursing. Let these decisions be our own and let them be wise. Let them consider all the future registered nurses and let us never be guilty of dividing our own members.

GRACE TAYLOR, Ontario

Dear Editor:

I do not know why a fine magazine such as *The Canadian Nurse* continues to run an advertisement for a postgraduate course in ophthalmic nursing in a hospital which, in my opinion, is far below the standard to be expected of such an institution.

A hospital that accepts registered nurses from many countries for postgraduate work is surely expected to offer some degree of good academic training and nursing care but this is hardly the case at this particular American institution.

Nurses are quite prepared to give service to a hospital offering such a course for a small remuneration and *good* teaching. However, it is surely not unreasonable to expect the stipend to be closer to the amount quoted in the advertisement and the teaching to be closer to that quoted in the hospital's brochure.

Ophthalmology is a specialized field requiring understanding of specific skills and techniques. It is also essential that nurses know how to aid the visually handicapped to understand and accept their loss and continue to feel a part of the sighted world. Nurses must also understand this loss and be able to help educate the public to accept the visually handicapped. Where else but at an eye hospital would one expect to learn all of this? Since little or no clinical teaching was offered on the wards of the hospital in question this learning was simply not possible.

Disappointed Canadian

¶ *We would be interested in hearing from other Canadian nurses who have encountered similar problems in postgraduate work in the United States, particularly if the agency is advertised through these pages. Such information will be regarded as confidential if desired and requested, although we would ask your permission to draw to the attention of the institution the fact that such a complaint has been received.* Ed.

Cycloid therapy in the joints of chronic rheumatoid arthritics: "... was proven to be simple, safe and effective in the cases studied. There is an immediate, repeatable, beneficial effect of treatment in that pain, muscle spasm and stiffness are diminished in nearly all instances which lasts from forty minutes to two or more hours."*

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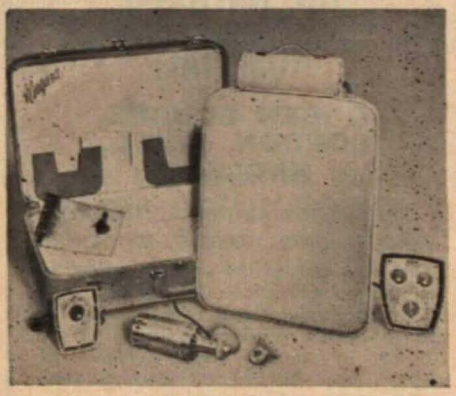

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Dear Editor:

I am greatly enjoying *The Canadian Nurse*, and feel it is a very stimulating and informative magazine.

I am leaving for a visit to Finland in a few days time. Plan to take a few issues of the Journal with me to show the nurses over there what a *good* nursing journal looks like!

(Mrs.) HARRIET E. GOUVEIA, Quebec

Dear Editor:

Ever since I began working in the United States many years ago, I have subscribed to *The Canadian Nurse*. I would like to express my appreciation of the consistent value of the articles published. I subscribe to keep informed about Canadian nursing. In some of the schools in which I have worked there was a library subscription, but I also added my copy.

Although a faculty member, I am not teaching. I donate my magazine to the nursing school library, and it is used considerably by both students and teachers. Much of the material is very useful for its practicability.

I have read Mrs. Margaret McDonald's letter in the July issue. I receive other professional journals with the dues, and I should think she would be glad to be kept informed about Canadian nursing, and to read other inspirational and practical articles that are published.

I bring to her attention, also in the July issue, the lead article, "Who Speaks for Nurses and Nursing?" Here is a message for all professional nurses, everywhere.

ETHEL M. HILLYARD, R.N., Chicago, Illinois

* * *

Nothing is more despicable than a professional talker who uses his words as a quack uses his remedies.

— FRANÇOIS DE FÉNELON

(Continued from page 906)

generations, communication between the isolated fishing villages along the Atlantic seaboard was restricted to occasional visits by boat. So you can still hear English pronounced as it was three centuries ago or the rich burr of an Irish brogue. No where in the world will you find warmer hospitality.

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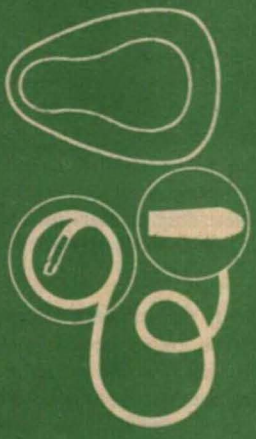

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Writing has no purpose save to meet the needs of the reader. Before the days of the pony express and airmail, communication on this continent was by smoke signal. When the Indian was making signals it was he and not the friend who got smoke in his eyes. Let's absorb the smog at the point of origin, so that our communications arrive crisp and clear.

— *The Royal Bank of Canada Monthly Letter*

Effects of Aging

Many manifestations of aging, previously considered to result from the aging process itself, may be attributed to other causes. Collaborative studies by a team of twenty-one scientists at the National Institute of Mental Health, National Institutes of Health, Bethesda, Maryland, indicate that social, personality, and health variables all appear to be of considerable importance in explaining changes that occur in older persons.

The studies were designed to explore the effects of normal aging. The studies involved 47 medically healthy males, living in urban communities and ranging in age from 65 to 92, with a mean age of 71. This was in contrast to many earlier studies which focused on persons who were sick or institutionalized. In general, the men exhibited mental flexibility and alertness, and were found to be constructive, resourceful and optimistic. They did not display the stereotyped "rigidity" commonly believed to accompany old age.

The intellectual performance of the aged group reflecting verbal abilities was found to be superior to that of young normal controls, although evidence of diminishing function was observed in other tests, particularly in psychomotor speed. The chronological age of those who exhibited symptoms of a mild, early mental decline did not differ from the chronological age of those without such symptoms. Thus the investigators were led to question the commonly accepted importance of chronological age as an overriding factor in the development of psychiatric disorders in the aged.

The social factors in the subject's immediate environment were found to be very closely related to his behavior and attitudes. If the social environment showed qualities of deprivation, as, for instance, in the loss of intimate persons or loss of income, the subject's attitudes and behavior showed more deterioration and manifestation of depression. Whether or not enforced retirement has unfortunate consequences for the individual depends to some degree, the investigators found, upon whether or not the retirement was accompanied by conflicting internal and external pressures.

Contrary to expectations, studies of cerebral circulation and metabolism revealed

Her mother might help, but

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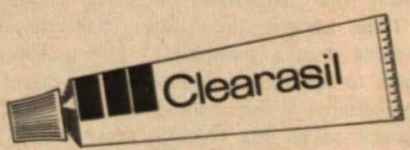

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— *U.S. Dept. of Health, Education and Welfare.*

In the Good Old Days

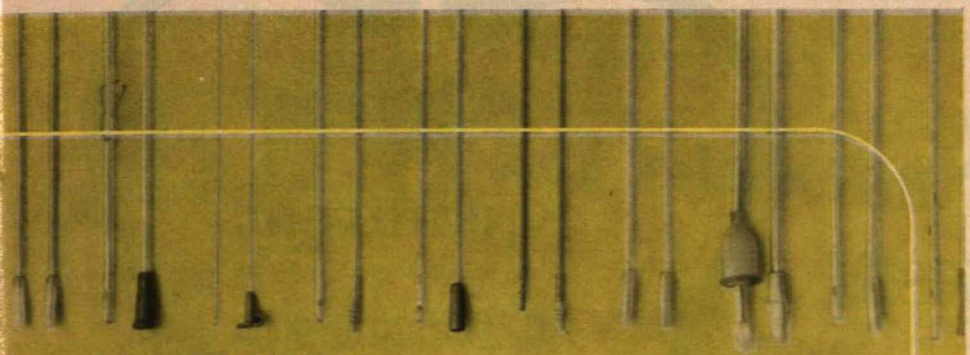
(*The Canadian Nurse* — OCTOBER 1923)

In as much as it is a punishable offence to run a business without a proper system of accounts, so it should be to run a school of nursing without records. Every well-conducted school sends home a monthly progress report with each pupil. Why should not a nursing school also give its students an inkling now and then as to *their* progress and the opinion their teachers have of them ?

* * *

The great majority of people are credulous. There is a quite common temper of mind which leads people to turn from science, with its honest, cautious, and often unsuccessful gropings after truth, and to accept, in preference, the professions of those whom their very ignorance makes loud and confident in statement. This is well illustrated by the following story:

A celebrated quack was visited by a former playfellow from his native village, who asked how he got on so well, adding, with the frankness of early friendship, "Thee knowst thee never had no more brains than a pumpkin !" The quack took him to a window and bade him count the passers-by. When a hundred had passed the quack asked his visitor, "How many wise men do you suppose there were among this hundred ?" "Maybe one," was the reply. "Well," returned the quack, "all the rest are mine." To this enormous percentage of mankind quack advertisements make their appeal.



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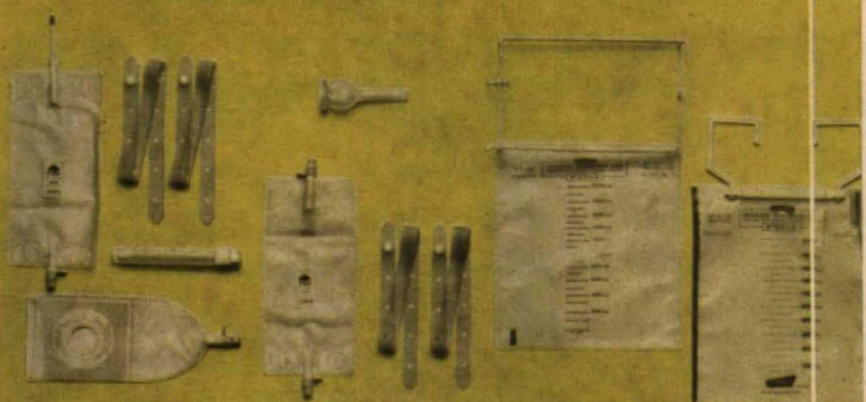

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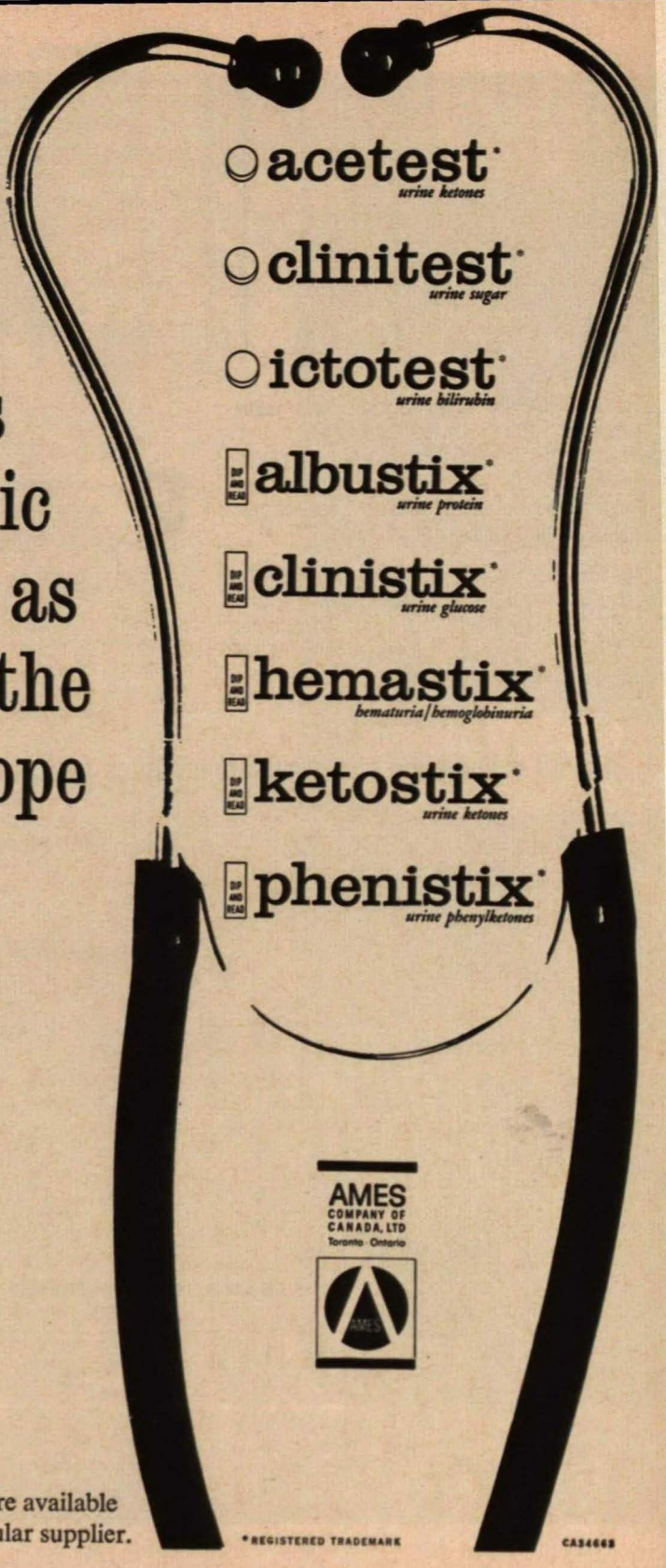

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* * *

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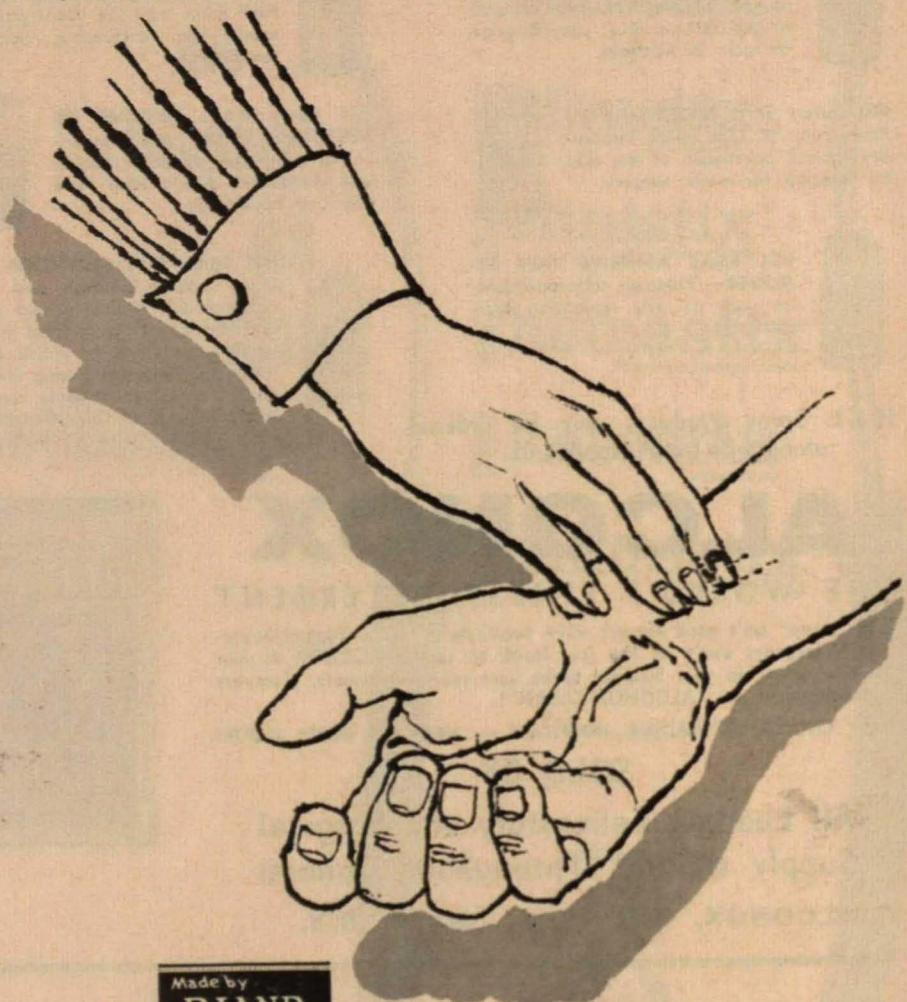

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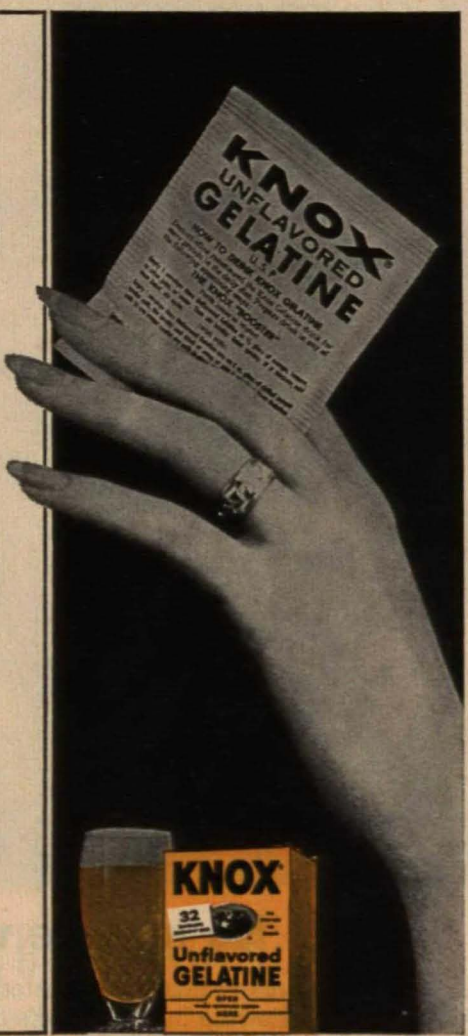

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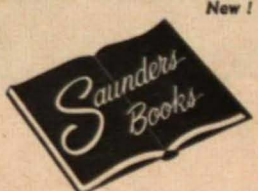

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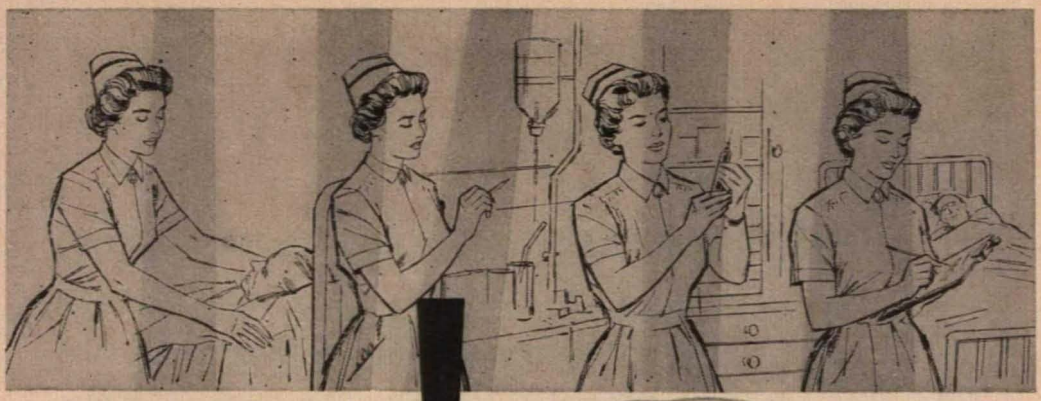

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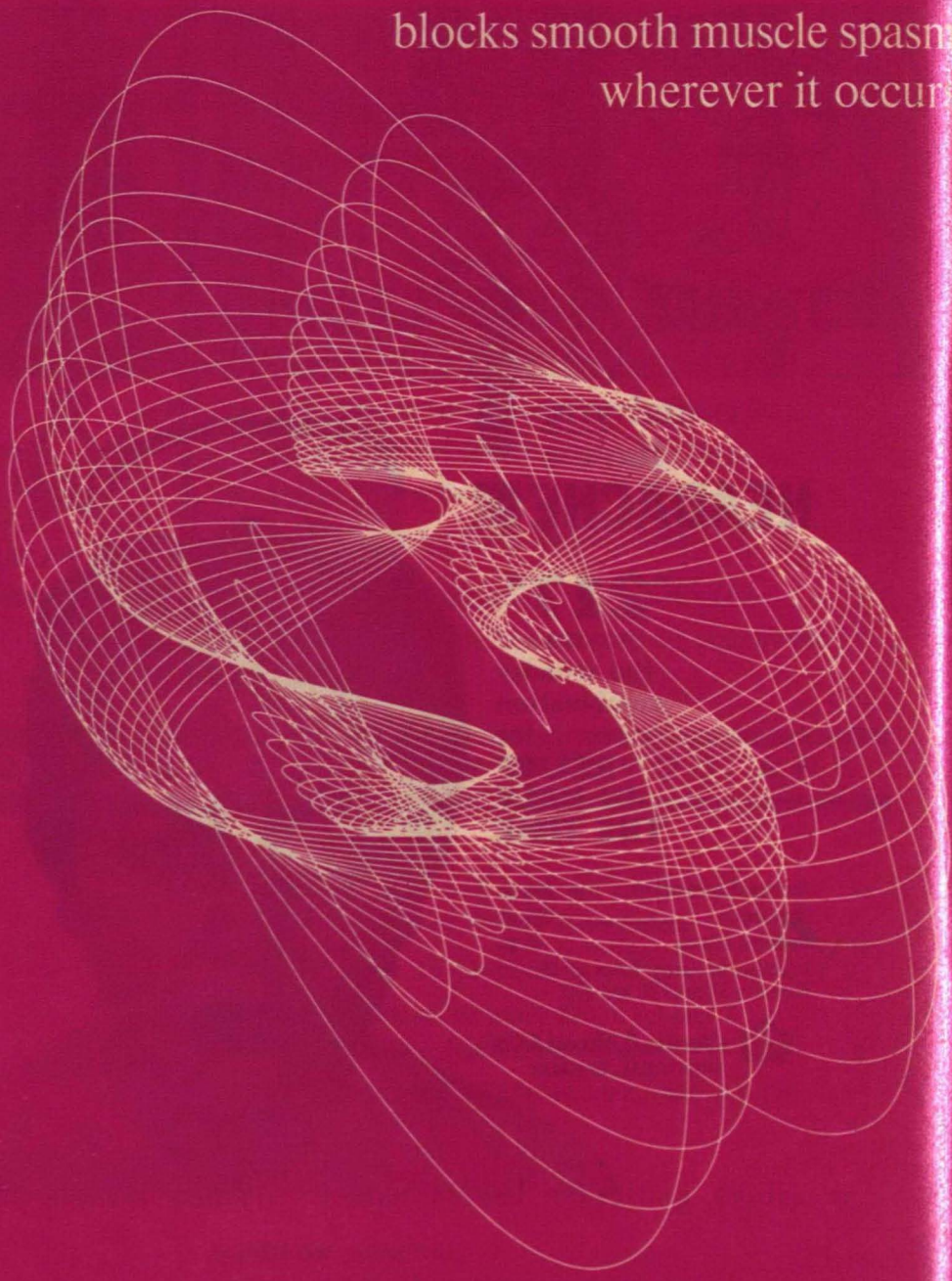

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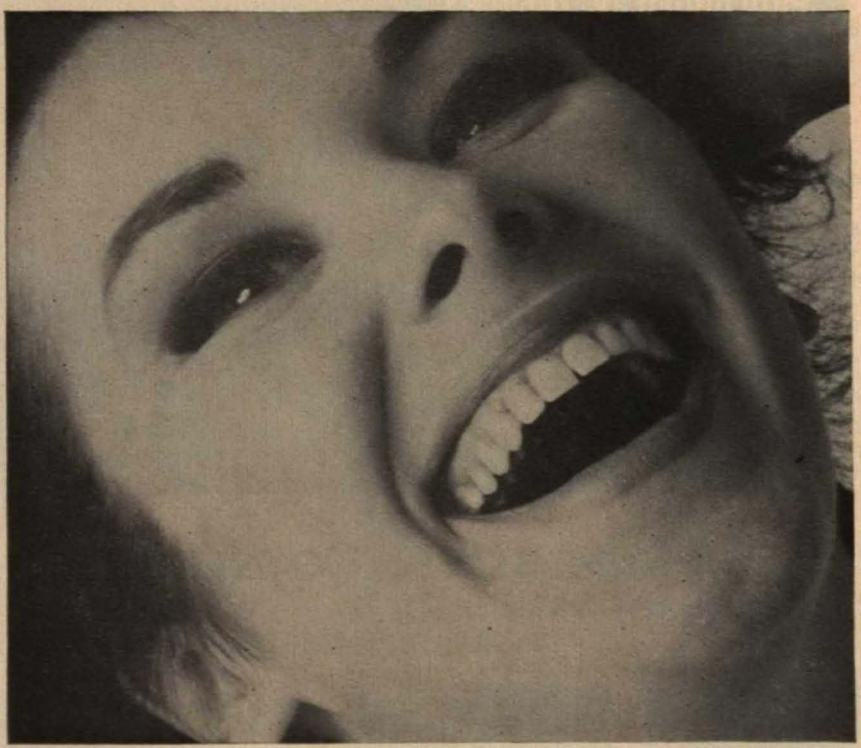

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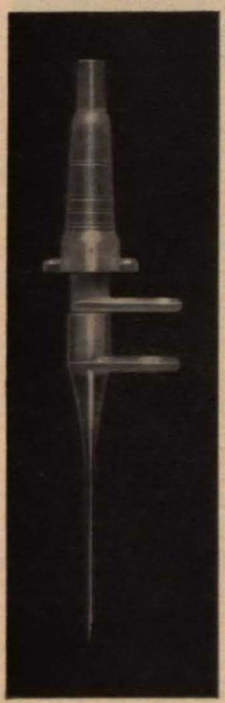

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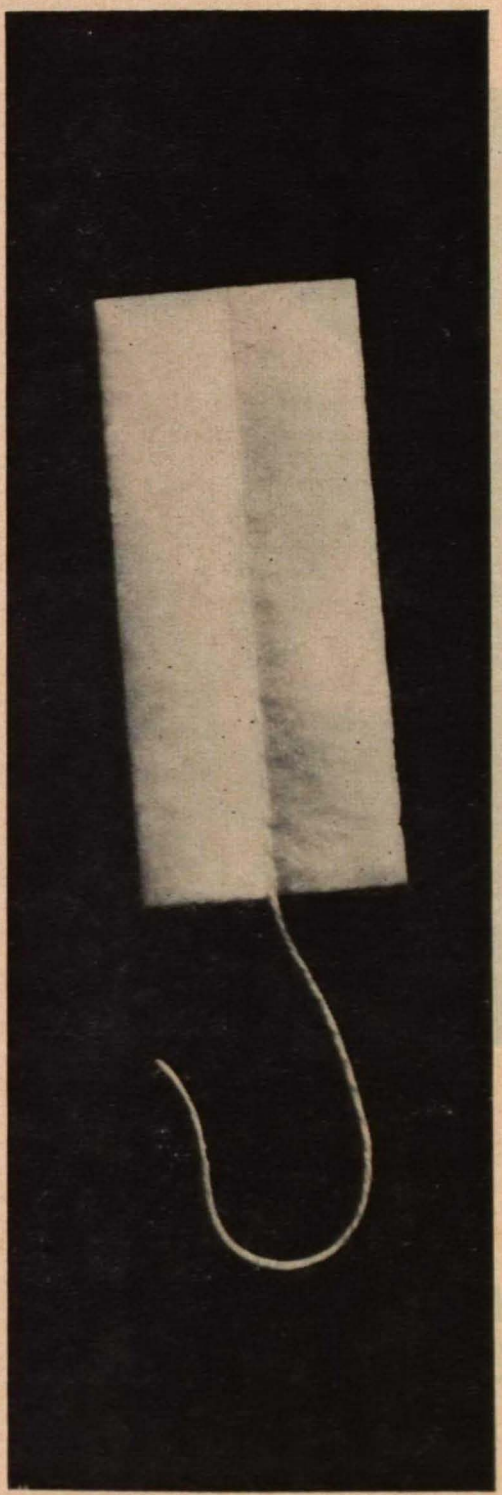

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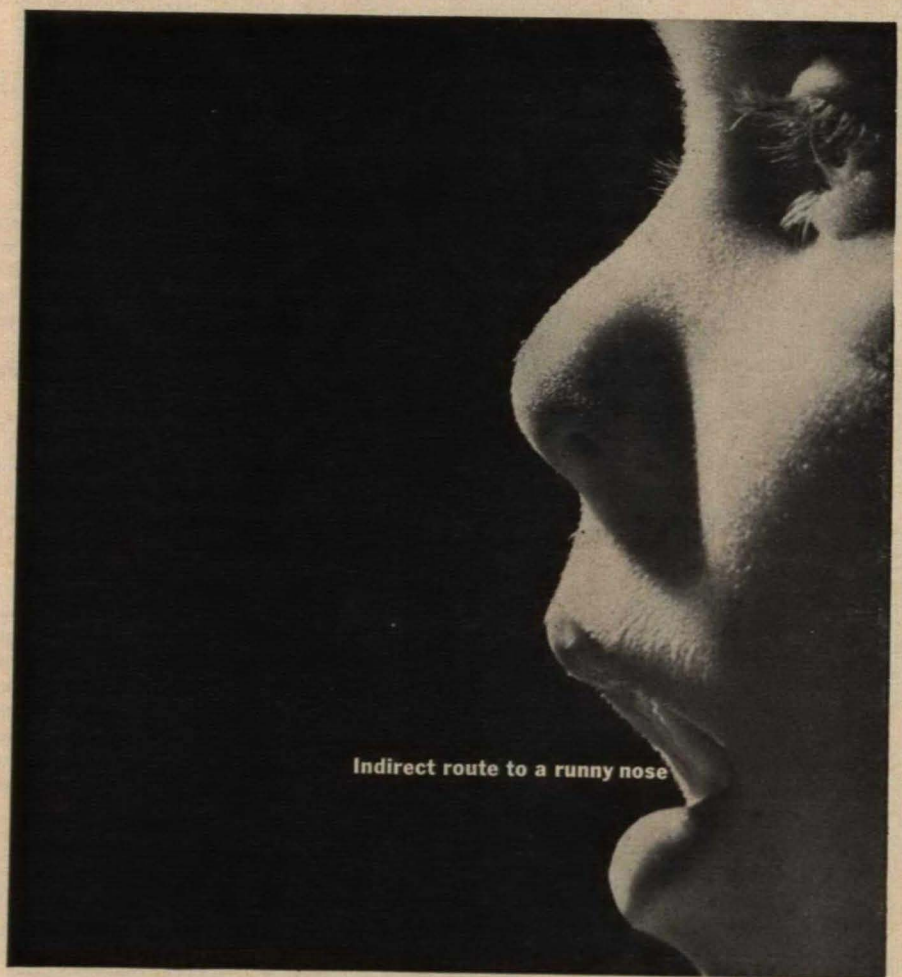

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VOLUME 59 MONTREAL, OCTOBER 1963 NUMBER 10

Changes in Nursing Education in Saskatchewan

LINDA LONG, M.A.

The changes in nursing education proposed for schools of nursing in Saskatchewan are in the areas of: Administration and organization; teaching staff; students; educational facilities; curriculum. They resulted from a five-year study project by a subcommittee of the provincial Committee on Nursing Education. Approval for them was given by the Council of the S.R.N.A., supported by a resolution presented by the Association's general membership at the Annual Convention, May 1963. How to implement these changes is the present major project bringing with it the interesting challenges any change initiates.

Miss Long is the Association's advisor to schools of nursing in Saskatchewan.

WHY CHANGE?

The reasons for change in nursing education are numerous and cannot be identified only with Saskatchewan, but must be associated with Canada and, in some instances, other countries.

1. Patterns in general education are changing. There is increased emphasis on higher educational preparation. Educational opportunities for a high school student have increased in scope, so that the nursing profession is forced into more competition with other professions for the desired student applicants.

Hospital schools of nursing in Canada have a great need to develop their programs on a sounder educational basis. A diploma school of nursing program developed on a sound educational basis can be carried out

under three years without sacrificing the qualities required for a new graduate thus taking less of the student's time and availing the public of graduate nurses more quickly.

2. The graduate nurse's functions are changing and need clarification in order that an educational program can be designed to prepare nurses to meet modern demands. This clarification and designing must be done by nursing leaders and supported by all nurses. Changes in the nurse's function are attributed to such things as:

Changes in medical practice, both curative and preventive;

changes in type of medical conditions;

more emphasis on rehabilitation;

increased number and kind of diagnostic procedures;

increased services of other personnel on the health team;

the fast growing nursing assistant program in Canada;

a more informed and health-conscious patient as the result of increased emphasis on preventive health;

changes in the cultural and social practices of our society.

3. The most common questions asked about nursing are in relation to the supply of nursing personnel. Why is there such an increased demand for nurses? Why is there such a loss to the profession of student nurses who, for a variety of reasons, discontinue their nursing education? Why do so many qualified graduate nurses leave nursing? Are the best administrative skills being used for the most effective utilization of available nursing staff? Do nursing administrators recognize and assume responsibility for continuing the education of nursing personnel? What are schools of nursing doing to lessen student nurse withdrawals; increase enrollment of students with the desired qualities; overcome the shortage of qualified nursing instructors?

Many more questions of equal importance could be posed and deserve an answer.

Nursing leaders in Saskatchewan have long felt the need to upgrade nursing education in their province, so that it would not only meet student needs, but also that better patient care would be provided. The intensity of these feelings provided the high degree of motivation necessary for critical self-evaluation and initiation of plans for suggested changes. Evidence of this can be seen in:

Formation of the Centralized Teaching Program in 1953 and its development in 1963 from a four-month to a seven-month teaching program. Six of the eleven schools of nursing in the province are involved.

Publication of the *Basic Nursing Education Study* by Louise M. Schmitt in 1957;

Publication of the *Cost Study of Basic Nursing Education Programs in Saskatchewan* by Lola Wilson in 1959;

The Ad Hoc Committee set up by the Saskatchewan Registered Nurses' Association in 1960, as a result of accumulated dissatisfaction with nursing education and practice. Its main purpose was to define the problems and needs in nursing education and nursing service in Saskatchewan.

Introduction of an experimental two-year basic nursing education program in 1963 at the Regina Grey Nuns' Hospital School of Nursing. A sample group of 20 students was selected from the class enrolled in September, 1962 for the three-year diploma program.

Briefs presented by the Saskatchewan Registered Nurses' Association to:

a. The Royal Commission on Health Services, January, 1962. Terms of reference were:

Methods of improving existing health services;

the correlation of any new or improved program with existing services for the provision of better health services;

the present and future personnel requirements to provide health services.

b. The Department of Public Health, Province of Saskatchewan, January, 1963.

This brief reemphasized the terms of reference in the Royal Commission brief; presented and requested support for proposed changes in the pattern of administration for schools of nursing and their educational programs.

The Department of Public Health has not only given financial support to all of the basic educational programs, but has shown keen interest in and provided encouragement for leaders of nursing in the province.

PROJECTED CHANGES

Administration and Organization

Too many hospital administrators,

whose prime function is hospital management, are speaking with authority for our schools of nursing. The Saskatchewan Registered Nurses' Association controls, at least in theory, the education of nurses seeking registration. Its future objective is accreditation of all schools of nursing in the province. In order to reach this goal, one of the first and most essential changes to be made, effective January 1965, is in the area of administration and organization of the school. It is proposed that:

The school of nursing shall have its own governing body. The responsibilities of this body are already defined;

the school of nursing shall have an Advisory Committee. The responsibility of this Committee has been defined;

the director of the school shall have increased authority to direct the school of nursing in all its aspects;

the school of nursing shall operate on a separate budget to provide for educational and maintenance costs. Areas of income and budget items have been suggested. One possible area of income is student tuition fees which are not presently required in hospital diploma programs in Saskatchewan.

Teaching Staff

An insufficient number of full-time, qualified teachers has been a major problem in Saskatchewan hospital schools of nursing. The cause could be attributed mainly to control of the budget by hospital administration and the lack of deadline dates laid down by the Association for the employment of a sufficient number of qualified teachers. In order to achieve accreditation a school of nursing should have a sufficient number of qualified teachers. Most of the following proposals are to become effective in January 1965:

The director of the school, as well as her assistant, shall have a baccalaureate degree by January 1965, and a Master's degree by January 1970, as well as five years postbasic nursing experience of which two years shall be in education;

the teaching staff shall have certificates in teaching by January 1965, and baccalaureate degrees by January 1970;

the ratio of full-time teaching staff to the total student body will be at least 1:10;

personnel policies and practices shall be established and maintained for the school of nursing staff. Items included are: salaries; working hours, conditions and practices; provision for inservice educational programs; opportunities to pursue further studies.

Students

Nearly 60 per cent of student withdrawals from schools of nursing in Saskatchewan are due to academic failure. The next most common reasons are marriage and dislike of nursing. The greater percentage of academic failures can be attributed to poor selection of students because of an inadequate number of desirable applicants and pressure for numbers by hospital nursing service. Many students who withdrew due to dislike of nursing, might have been helped by an effective counselling program. The major changes proposed by the SRNA relate to admission requirements and counselling programs. By January 1965, all applicants must have Grade XII standing with the equivalent of university entrance. Other criteria than that of age must be used to assess the applicant's maturity and suitability for nursing. An organized guidance program should be maintained to help students make educational, personal and professional adjustments. Other areas of change or reemphasis are in relation to health programs, living accommodation and transfer or withdrawal of students from schools of nursing.

Educational Facilities

Most schools of nursing in Saskatchewan lack adequate office space, classrooms and conference rooms for effective school administration and practice of the proposed educational program. This may be attributed mainly to the leadership, or lack of it, given by the administrative personnel of schools in relation to the schools' needs. Evidence of this was seen in the variety of facilities available as well as in the differing stages of growth and development of programs. Another cause could be the control of budget by hospital administration whose main concern is the provision of beds and equipment essential to the care of a patient.

In order to conduct an effective ed-

ucational program, it is essential that the school of nursing should have separate administrative offices. An adequately equipped and conveniently situated office should be provided for each instructor in order to permit her to function more effectively. Sufficient number and size of conference and classrooms should be provided as well as properly equipped laboratories so that more satisfactory development of the educational program can be accomplished. Functional libraries should be established with consideration of such factors as size, situation, facilities, reference material and an established system for the most effective use of this material.

For a school of nursing to achieve its objectives, a sufficient number and variety of nursing experiences must be offered in the hospital and the surrounding community. A hospital conducting a school of nursing must show a rated capacity of at least 150 beds and a daily average of at least 120 patients by January 1968. Where clinical resources are inadequate, affiliations and field experiences must be provided.

Curriculum

According to the Ad Hoc Committee Report in 1961, nursing as well as the total health needs of our population have altered due to rapid social changes. This has changed the requirements as to quantity and quality of nursing service which, in turn, has made available patterns of education inadequate. Before a new curriculum can be designed nursing must be clearly defined in relation to the nurse's functions and the patient's needs. The curriculum should challenge the Grade XII graduate so that desired applicants may be obtained and student withdrawals lessened.

Against this background, a philosophy and definition of nursing were stated, discussed with representatives from all schools of nursing in Saskatchewan, and accepted by them. These statements formed the basis for the description of the aims and objectives of a new proposed curriculum. Again, all schools of nursing shared in a general discussion of them. Acceptance was granted following some alterations. The SRNA Council accepted this philosophy and the definition of nursing as official for Saskatchewan. The acceptance of the aims and objectives, as described and proposed by the subcommittee to the Committee on Nursing Education provided guidance for the province's schools of nursing concerning their responsibilities in a nursing student's education. A minimum curriculum was developed and presented to administrative personnel representing nursing service and education in hospitals conducting a school of nursing. Suggestions from this group were valuable and guided the subcommittee in further development of the curriculum. The suggested curriculum was presented and accepted by the Association's general membership at the annual convention, May 1963.

PROPOSED MINIMUM CURRICULUM

Perhaps the most striking difference in the new curriculum is the grouping together of subject matter and experience so that there are now only six areas of correlated theory and practice. Other innovations are the reallocation of hours of theory and the statement of required practice time in hours rather than in days or weeks. Public health nursing does not appear as a separate entity but its concepts are woven into each of the six courses.

The major areas of change are:

1. The minimum length of the program shall be 22 months, exclusive of vacation;

2. the minimum hours of instruction shall be 1000 as compared to 812 hours as presently recommended;

3. the minimum hours of supervised practice shall be 1200. This replaces the former minimum *number of weeks* for each clinical experience and the assumption that during that period the student had received the experiences necessary for her learning. In all honesty we know that during these periods in the clinical area, nursing service demands another pair of hands and feet; gives limited direction because of the nature of its work; expects more than a student is prepared to do. The amount of planned teaching and supervision of students in the clinical areas is limited and, in some cases, very questionable. Therefore, it was necessary to state a minimum number of supervised practice *hours* which could be corre-

lated with the theory and which would serve to protect the student's education and the safety of the patient.

4. The six major course areas are:

A. *Behavioral sciences and humanities:* The required minimum of instructional hours is 300 as compared to the present average of 80-90. This proposed minimum of instruction includes human growth and development; communication skills; ethics; psychology and sociology. The primary reason for the increase in the hours of instruction is to provide greater depth and breadth of knowledge for the student, rather than presentation of introductory material. The introduction to the behavioral sciences will be given early in the program; later courses will build on and broaden these concepts. It is also hoped that this will provide more opportunity for the student to develop skills in human relations.

B. *Physical and biological sciences:* The required minimum of theory is 200 hours, as compared to present figures of 170-210, and 100 hours for laboratory practice, as compared to the present 20-90. The major change in these sciences is to recommend an increase and a definite period of time spent in the laboratory. This should provide more opportunity for a student to develop a sound knowledge of scientific principles which would assist her in the development of good nursing techniques. Anatomy, physiology, microbiology, pharmacology and pathology are included in this course.

C. *Foundations of nursing:* The required minimum hours of theory is 140 plus 160 hours for supervised practice as compared to a total of 200 hours of theory and supervised practice as presently recommended. It includes fundamentals of nursing, history, trends and professional adjustments. The major change is the recommendation of a definite period of time for supervised practice so that students would be assured of increased direct supervision by an instructor. This is essential in order that the student should be provided with adequate opportunity for the development of the basic skills necessary for effective patient care.

D. *Nursing of adults:* The required minimum hours of theory is 240 with 480 for supervised practice. This course integrates medicine, surgery, psychiatry, diet therapy, communicable disease and pharmacology. The major change is in the approach. Nursing of adults is structured to be taught as a whole course incorporating psychological principles throughout. It will consist of both classroom and clinical experience designed to provide the student with the essential knowledge and practical experiences required in the care of adults. Should the number of patients suffering from mental illnesses be too limited to provide adequate experience for the student, their nursing care may be taught as a separate entity. At present, segmented teaching of each subject is done in the classroom and clinical areas with the hope that the student will see it as a whole in relation to the total health needs of an adult. We, as teachers, add to the student's problem by cluttering essential information with unnecessary and ineffective repetition of material.

E. *Nursing of mothers and children:* The required minimum of theory hours is 120, with 240 hours for supervised practice. This course encompasses knowledge of obstetrics, pediatrics and those aspects of medicine, surgery and communicable disease related to mothers and children. The major change is in the approach since this aspect of nursing is structured to be taught as a whole course. The characteristics of the well baby and mother are emphasized as well as the family's role and the influence of one member upon another. The course will consist of classroom, clinical and community experience designed to provide the student with the essential knowledge and practical experience required in the care of mothers and children. Segmented teaching, as well as cluttered information, is presently being given to students. Emphasis on the mother or child as a member of a family and the effect of illness, birth or hospitalization on each member of that family should provide for more effective nursing.

F. *Advanced nursing:* The required minimum is 200 hours of supervised practice. This course is new and is designed to summarize and correlate concepts that have been developed in previous courses and to extend the student's understanding of the patient's

needs beyond the immediate hospital setting. There should be demonstration and practice of nursing care at a more advanced level than that which the student had previously been expected to do. She should be provided with the opportunity to see the importance of and to accept responsibility for assessing the patient's needs; planning for nursing care; delegating some aspects of care to others; supervising and evaluating the care given by others. It is hoped that this stage will help the student to develop a more acute awareness of her role as a graduate; to be a more competent practitioner; to contribute more effectively as a new graduate than her predecessors.

THE NEXT STEP

Some changes have already come about. Provision was made from the very beginning of the five-year study for all schools of nursing to participate in each developmental stage of the project. Each stage was accepted by the schools and the SRNA Council before final steps were taken. The proposed administrative changes and minimum curriculum were presented to the adminitrative personnel of nursing service and education for interpretation and suggestion before completion. They were presented to and accepted by the Association's general membership in May 1963. The Department of Public Health's support of the proposed changes was requested with special attention to accompanying administrative problems. These problems pertained to budgeting of money, nursing service and educational personnel, and to regulations for nursing students included in the Hospital Standards Act. The support given by this department to date can be seen in the audiences granted to members of the Associations' Council; financial assistance granted for extension of the Centralized Teaching Program, the experimental two-year program, and all basic nursing education programs; suggestions requested for changes in regulations governing nursing students. The SRNA Council responded to the latter request.

Workshops are planned for all schools of nursing so that course outlines can be interpreted and discussed, and guidance given to teachers concerning their respective subjects. Fortunately, the CNA School Improvement Program workshop for Saskatchewan, held in September 1963, served as a good background for planning the other workshops. This special workshop concentrated on the need for and description of the philosophy, aims and objectives for a school of nursing. With consistent guidance and support from the provincial nurses' association, Saskatchewan schools of nursing can improve and accreditation can be achieved.

WHAT OF THE FUTURE?

The future is the tomorrow that we think about today. My thoughts concerning the future of nursing education in Saskatchewan are limited to my knowledge of nursing in this province. Much depends upon the professional solidarity of the provincial association's membership. According to Dr. Rae Chittick, implementation of change is often hindered because the "membership in general does not welcome innovations and is too prone to find the weak areas in any new departures." How many professional nurses accept leadership responsibility in the development of their profession ? How many are critical of the weak areas without trying to see the profession as a whole and offering ideas to strengthen weaknesses?

What will be the educational pattern for students in a diploma program? The development and extension of the Centralized Teaching Program provides a framework for establishing central teaching of the total program. This could lead to a complete pre-nursing curriculum, composed of basic social, biological and physical sciences, which could receive university credit. The students would pay tuition fees similar to those in other educational programs. The second stage of development could be extension of the curriculum to include selected clinical experiences in hospitals presently conducting schools of nursing and in other community agencies. Combining the pre-nursing program and clinical experience in one curriculum would re-

quire only 22 months for completion. The student's tuition fee would be extended to include the clinical experience. All hospital schools of nursing could eventually become involved, beginning with the smaller and geographically handicapped schools. The larger, centrally located schools might never be involved. It is possible that they would be separated from the hospital with their own administrative control and with programs similar to that offered by the Centralized Teaching Program.

The years ahead will be interesting and challenging as changes are implemented and results of experimental programs made known. Wise leadership will be necessary; prudence and faith must steer the ship of nursing education into the future.

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Invitation to Newfoundland

At the closing session of the Vancouver Biennial in 1962, MISS JEAN LEWIS, *president, Association of Registered Nurses of Newfoundland, extended this gracious invitation to the members of the Canadian Nurses' Association.*

Madam Vice-President, honored guests and fellow nurses:

I am sure by now there is no doubt in the minds of all present as to why I am on the platform.

I come before you with very mixed feelings, conscious of the fact that we are the youngest members or sisters of this very large family. This is a very proud moment, not only for myself, but for all the members of our provincial association, as I have the opportunity of speaking to you.

The old saying, "one should be seen and not heard," does not apply in this family. From the moment one is accepted as a member, she is encouraged to take an active part and to give her opinions.

Since we were formally accepted as members of the Canadian Nurses' Association, we have had many opportunities to air our views, and take part in the projects of our national association. We hope by now that we have grown sufficiently to be able to take an even greater part in the activities of the C.N.A.

During the past 13 years the province of Newfoundland has received a fair amount of publicity, some good and some bad. In spite of the latter, people from the other nine provinces have ventured to visit our shores to see what this newest province and its people are really like.

Newfoundland is rich in history. For the artist, there are scenic wonders of entrancing beauty; for the lover of outdoor sports, there are unrivalled opportunities for trout, salmon and tuna fishing. The climate is temperate, cooled in summer by winds coming up from the sea. I fear that if I continue in this vein, I may be mistaken for a member of the tourist bureau trying to

promote the tourist trade. May I quote from the pen of Lt. Col. William Wood, a noted Canadian author and historian, the following picturesque tribute to Newfoundland and Labrador.

Newfoundland is an island of the sea, if ever there was one. Nowhere else does the sea enter so intimately into the life of a people — calling, always calling them — loudly along a thousand miles of surf-washed coastline, echoingly up a hundred resounding fiords that search out the very heart of the land, whisperingly through a thousand snug little lisping tickles, but calling, always calling its sons away to the fishing grounds and sometimes to the seafaring ends of the earth.

Labrador is a wild land, ruthless and bare and strong, that seems to have risen overnight from chaos, dripping wet . . . It is indeed very much as the Great Ice Era left it thousands and thousands of years ago. But even glacial times are modern compared with its real age. Its formation is older, far older than man; it is older than the original progenitors of all our fellow beings millions of years ago. It is the very core of the great azoic Laurentians, the only land now left on the face of earth that actually stood by when Life itself was born.

From time to time over the past eight years some of our nurses have been asked by nurses of other provinces, "When is the Biennial meeting going to be held in Newfoundland?" This has been discussed on many occasions by the Executive of our provincial association, but because of lack of adequate facilities we have not been able to entertain the thought. Now, with the completion of our new university, and with other modern buildings under construction, we feel that the problem has been overcome.

A meeting of this kind at this time will do much to increase the interest of individual nurses in our own province, as well as affording nurses from other provinces the opportunity to get to know us better. It is most timely that the next biennial meeting should be held in Newfoundland because in June 1964, we will observe our 10th anniversary as members of the Canadian Nurses' Association. We hope that as many nurses as possible will be able to attend to help us to celebrate this occasion. We will assure you, one and all, of a very warm welcome.

Madam Chairman, on behalf of the Executive and members of the Association of Registered Nurses of Newfoundland, I have much pleasure and pride in extending to the members of the Canadian Nurses' Association an invitation to hold the 32nd Biennial Meeting in St. John's, Newfoundland, in June 1964.

Coming!

IN

NOVEMBER 1963

Grant — Common Deformities of the Foot

Moncrieff — Care of Patients in Plasters

Taylor — Spondylolisthesis

Bolitho — Menisectomy

Storie — Legg-Perthes' Disease

Ramsay — Observations of a Ward Patient

plus additional material

COLLECTIVE BARGAINING and the PROFESSIONAL

JOHN H. G. CRISPO, PH.D.

As long as professional groups remain in control of their own collective bargaining, the ends and means will be subject to their control.

How should the earnings and other conditions of work of professionals be determined? A number of on-going developments in the world of the professions are bringing this question into ever-sharper focus. Among the more important of these developments are the following:

1. The number of professionals in the Canadian labor force has been increasing at almost *three* times the rate of growth of the labor force as a whole. During the decade of the fifties the number of technicians and professionals in Canada increased by 71 per cent while the total labor force grew by only 24 per cent. If current American forecasts are of any relevance in Canada — and there is every reason to believe that they are — a continuation of this proportionately higher growth rate can be anticipated in the future.

2. There is a steady rise in the proportion of professional persons who are not self-employed. Although there are no over-all figures to bear this out, many professional groups readily admit that more and more of their members are practising their profession and earning their livelihood in an institutional setting. What is perhaps of even greater significance is the increasing percentage of the latter who appear to be finding employment in public or publicly subsidized enterprises.

Naturally enough, these trends are likely to compel a continuing re-examination of the traditional manner in which the salaries or fees and the working conditions of professionals are determined. In an effort to discover what is going on in this field, I have been conducting a preliminary investigation of the ways in which various professional groups are coping with these matters. Before presenting these initial findings I shall clarify the meaning which I attach to the expression *professionalism* and to the concept of *collective bargaining*, and briefly discuss the incompatibility which is sometimes alleged to exist between the two. I will then outline some of the implications which seem to flow from these studies with respect to current "collective bargaining practices" in the nursing profession.

Dr. Crispo is assistant professor of industrial relations at the University of Toronto School of Business. He presented this address at the annual RNAO conference in Toronto.

PROFESSIONS AND PROFESSIONALISM

Many definitions have been offered to describe the major characteristics of a profession. Most of the conventional definitions tend to stress such things as the nature of the service provided (to be professional it is supposed to be highly refined and individualized), the education and training required (it apparently should be specialized and of an order equivalent to that offered in our highest institutions of learning), and the manner in which the occupation is governed (to be among the elite of the professional world a profession presumably should be subject to licensing by a self-governing association of those who practise the art).

A perusal of the many available

definitions of a profession is a discouraging business. Some of them are so elaborate and complex as to seem almost academic; almost all seem to be unnecessarily restrictive and confining; none of them really suits my temperament or purpose. In a state of desperation, I have therefore been forced to fall back on a definition of my own. Because it is neither ornate nor definitive it will no doubt offend the sensitivities of many. It has the advantage, however, of being relatively simple and straightforward:

> A profession is any occupation which requires an unusually high degree of skill, integrity and personal service.

To define a profession in this manner is to permit the inclusion of a variety of groups not normally granted such status — at least in the eyes of the traditional professions. It not only embraces the legal and medical fraternities and such groups as professional engineers, but also covers such other groups as policemen, professional athletes and entertainers. It might even be said to include — recent events notwithstanding — the professional politician.

COLLECTIVE BARGAINING

Before dealing with the question of whether or not professionalism (as I have defined it) and collective bargaining are compatible, I must also make clear what I mean by the latter. Like so many other concepts, the meaning of collective bargaining has been construed in an unnecessarily rigid sense. It has become so associated with the conventional union-management relationship that we tend to visualize it today only in the relatively narrow context. Yet I would argue that the usual union-management relationship is only one of the forms which collective bargaining may take. This is suggested by the following interpretation:

> Collective bargaining may be defined as any procedure by which representative groups of individual sellers of labor combine to participate in the determination of the terms which are to govern the provision of that labor.

Given this interpretation, it follows that practically any effort which any members of any occupation collectively take to influence the wages, salaries or fees and other conditions which apply to their services falls under the heading of collective bargaining. Whether a group seeks to better its conditions of work by raising standards and restricting numbers by publishing recommended wage, salary or fee schedules, by directly bargaining with employers, or by any other means, it is practising a form of collective bargaining.

ARE THE TWO COMPATIBLE?

Assuming there is any validity to the foregoing interpretations, it becomes most difficult to argue that collective bargaining *per se*, in all of the many forms that it may take, is incompatible with professionalism. If this is the case, then there is hardly a profession in North America that has not in some way jeopardized its professional standing. Almost every professional group, at one time or another, has engaged in some sort of collective bargaining. Yet few could be said to have compromised their professional integrity.

Experience would thus seem to show that there is no overriding and unavoidable incompatibility between collective bargaining and professionalism. As long as collective bargaining is not employed so as to infringe on the degree of individuality which is essential to the conduct of a particular profession, there need be no basic conflict between the two. Moreover, in some cases, the one may even reinforce the other. Where significant numbers of professionals are employed by large institutions, for example, institutional regulations may pose a serious threat to the profession. Speaking to this very point, as it has affected the nursing profession, J. B. Gillingham has observed:

> Thus, it is an issue of professional ethics if a nurse is assigned a patient load so heavy that she knows she cannot give adequate care... if a nurse is expected to perform tasks in a manner incompatible with professional standards... if a nurse witnesses non-professional personnel performing services which should be performed only by graduate nurses.

It is an issue of professional ethics if nurses permit themselves to be treated by supervisors, physicians, or anyone else, in such a manner as to injure their personal dignity and integrity or the prestige of their profession. It is an issue of professional ethics if, in the face of a shortage of nursing personnel all over the nation, nurses passively accept an economic status which discourages capable persons from entering the profession.*

Where issues such as these pose a threat to a profession, collective bargaining may provide the only effective way in which its members can protect its integrity. As society becomes more institutionalized this is bound to become an increasingly important consideration. In the face of such a trend, the profession which neglects the responsibility of collectively defending its interests could suffer immeasurable and irreparable harm.

While there is no incompatibility between the principle of collective bargaining and professionalism, this does not mean that in practice there is no possible conflict between the two. Collective bargaining may be employed for ends and involve means which are incompatible with professionalism. An example of the former would be undue emphasis on seniority and a downgrading of the importance of merit. In the latter category the possibility of a concerted withdrawal of labor immediately comes to mind. Whether this is incompatible with professionalism is a matter which will vary with the circumstances.

For those who are willing to reject collective bargaining because they fear the possible adoption of unprofessional ends or means, there is only one answer: *As long as professional groups remain in control of their own collective bargaining, the ends and means will be subject to their control.* Thus, unless the profession is prepared to contemplate unprofessional ends or means, these possibilities will not pose a threat. To argue that they will — as many members of individual professions do — is to question the integrity of their profession. If such questioning is warranted, then the profession is probably already in trouble and no amount of handwringing over the possible consequences of collective bargaining is likely to save it.

* J. B. Gillingham, "Collective Bargaining and Professional Ethics" *The American Journal of Nursing* (April 1950).

COLLECTIVE BARGAINING MODELS

Collective bargaining may follow various patterns in professional settings. For purposes of exposition, five specific collective bargaining "models," which even now can be found among some of the different professions, will be delineated. While there are obviously no clear-cut dividing lines between these models, I will assume for the moment that there are. This will enable me to describe them in a somewhat more precise style than is to be found in the world of reality.

In making this survey, attention has been concentrated on the role that the various professional bodies reviewed appear to be playing in the determination of the earnings of their members. This is admittedly a somewhat confining context but it does serve to illustrate what collective action may be expected to accomplish in "more professional" areas as well.

1. *Raising standards and restricting numbers.*

One very effective way in which professional groups can influence the terms under which they render their services is by insisting on ever higher standards and thereby limiting the numbers who can enter into the profession. Since it is often very difficult to sort out the true purpose of a rise in standards, this approach is subject to a variety of interpretations. In some instances, the profession may have no other purpose in mind than a general improvement in the calibre of service rendered by its members. The problem is that this is almost invariably associated with a reduction in the number of potential entrants into the professional and, barring a decrease in demand, a concomitant rise in the earnings of the members of the profession. Very often, therefore, there may be an element of truth in the argument that the true reason for a profession raising its entry standards is to increase the potential earning power of its members.

Regardless of the intent, there is no doubt that where a profession does have a great deal of control over the standards which apply to its members, this power can

be employed most effectively to influence the conditions under which those members will render their services. Fear of the arbitrary use of such power was one of the reasons why the Select Committee on Manpower Training of the Ontario Legislature recommended that no private group be given sole control over the standards applicable to any given trade, occupation or profession.

2. *Publishing recommended compensation schedules and more or less leaving it at that.*

It is quite common in a number of the professions for the professional association to do little more than publish a schedule of "fair" compensation (either in the form of salaries or fees or both), to serve as a guide to their members and to prospective employers and clients. Among the more prominent professions which have adopted this approach are the medical and legal fraternities and the professional engineers. In some cases they have legal sanction for carrying on these activities; in others they do not.

For the most part, the professions that have adopted this approach appear to place more reliance on market than institutional forces to increase their earning potential. They depend largely on the forces of supply and demand to raise their salaries or fees and only publish a schedule of the same in order to indicate the prevailing rates. By and large they do little to enforce them, probably because they do not really have to. As long as demand runs well ahead of supply for any given profession, one would expect this to be a perfectly satisfactory approach. The experiences of the nursing profession suggest, however, that this does not always follow automatically.

A deciding factor in determining whether or not this approach is likely to prove successful may be the way in which the professional service is offered. It is to be noted that, with the possible exception of the engineers, most of the members of the professions which have adopted this approach are self-employed. By reason of this fact they are very often free "to charge what the traffic will bear" and leave it at that. As long as there are shortages in the professions involved and the members remain largely self-employed, this will no doubt remain an effective arrangement — especially if combined with a significant degree of control over entry standards.

That it tends to be less effective where many members of the profession are not self-employed is suggested by recent developments within the Association of Professional Engineers of Ontario (APEO). This organization now publishes one of the most elaborate salary schedules in the province. Although it is well-conceived, comprehensive and widely known, it is published as a guide only. There is a significant minority within the APEO — exclusively composed of those employed by large institutional employers of engineers — which believes that this is not enough. In the past, some of them have gone so far as to advocate a type of bargaining for engineers similar to that practised by most unions. The debate which this group has engendered within the APEO reveals the cleavages that can emerge within a professional association when substantial proportions of the membership provide their services on different bases.

3. *Publishing recommended compensation schedules and doing something about it short of a withdrawal of services.*

Some professional groups have decided to take whatever action may be necessary short of a concerted withdrawal of labor to enforce adherence to their salary or fee schedules. Unlike the groups discussed in connection with the foregoing model, these professions tend to be populated by a high proportion of employee-members. Members of the nursing profession and university professors are among the most prominent of this group.

The weakness in this approach — as in the case of the previous one — lies in its ultimate dependence on the forces of supply and demand. Since there are few effective pressures that an organized employee group can mount against employers—other than some sort of a withdrawal of services — this approach is not likely to prove terribly fruitful. Unless the market is such as to force them to adhere to the views of their employees, few employers are likely to be very impressed with any recommended rate schedules unless they are quite close to what they were intending to adopt in any event. Even where there is a shortage in the profession — witness the current need for nurses — the employers may not be too impressed.

The point is that under any such approach the employee-members of a profession are bound to remain dependent on the tightness of the market for their services

or on the goodwill of their employers. Although some situations may lend themselves to the type of consultative arrangement that is necessary to give this approach any real meaning, this is hardly likely to be a very effective model unless the employers involved feel the need for it. Even then, in the absence of some means to ensure employer respect for their organizations, professional groups may not be in a position to play as effective a role as would be desirable.

4. *Ensuring adequate bargaining power by threatening to withdraw or actually withdrawing services.*

A few professional groups have been prepared to take the ultimate step of withdrawing their services in order to negotiate better pay and working conditions. The most noteworthy group in this category in Ontario are the members of the teaching profession. Although the various teachers' organizations in this province — the most sophisticated of which is the Ontario Secondary School Teachers' Federation — resort to what is normally termed a "pinklist" instead of a strike, to bring pressure to bear on individual school boards, it ultimately has the same effect. While the pinklist has been employed infrequently in recent years, willingness to use it in the past has had a lasting impact. The various teachers' organizations and the school boards do engage in a highly refined form of collective bargaining. Teachers have done very well by this process, and few would be willing to give it up. It is to be noted, however, that the forces of supply and demand have benefited the teachers immensely in recent years and raises have been readily negotiated. What will happen when the current shortage of teachers begins to taper off remains to be seen. At the public school level there are even now some signs that the teachers are finding it increasingly difficult to exact the concessions which they have realized in the past.

Other professional groups that are prepared to withdraw their labor in order to ensure effective bargaining power include newspaper reporters and members of the entertainment world. Whether this willingness has somewhat tainted their professional standing and integrity is debatable. It can be argued, of course, that just the reverse may have been the case.

5. *Giving up the right to withdraw services in return for compulsory arbitration.*

Certain professional groups have requested or submitted to compulsory arbitration as a substitute for the right to withdraw their services. Most noteworthy among these are the federation that represents many of the professionals within the federal civil service and many local police associations. In the case of the former, its request for compulsory arbitration has thus far been denied. In the latter instance, compulsory arbitration has been imposed but has not worked out too satisfactorily.

In view of the fact that compulsory arbitration may be the only effective alternative where a withdrawal of labor is not in the interest of either the profession or the public or both, it is distressing to discover that it has left much to be desired in the case of the police. Fortunately, however, there may be a simple answer to the problem. Police discontent with the results of arbitration to date may be a reflection of the choice of arbitrators thus far employed for this purpose. Very often the chairman of a police arbitration board in one community is a member of the judiciary in another community and sometimes he is actually a member of the police commission in the latter. In neither event is the choice of arbitrators a desirable one. The chairman of an arbitration board should be *completely neutral* and in so far as possible should bear no relationship — direct or indirect — to either one of the disputing parties. Only then is the arbitration process likely to be accepted as a fair and impartial substitute for direct action. Even then, however, it may not prove a fully satisfactory substitute for the right to collectively withdraw services. Unless arbitrators are guided by acceptable standards they may end up doing little more than reinforcing the status quo. How this risk might be overcome is a most challenging question.

AND THE NURSING PROFESSION?

Because of the nature of the service many of you provide and the dedication of your profession to the welfare of the infirm, you are rightfully reluctant to contemplate any form of withdrawal of services. The only time you might make proper use of this technique is in the case of those of your members who work in individual doctors' offices or in non-essential positions in general industry. In both of these cases use of procedures similar to those of the teachers would appear

to me to be a perfectly legitimate approach. For most of your members, however, this does not seem to provide a vital alternative.

Nurses are left in an unenviable position when it comes to the matter of bettering the conditions of their profession. In so far as this entails dealing with employers, you are really left with a form of *begging* rather than *bargaining* rights. This is illustrated by the failure of any major employer of nurses to be governed by any sort of formal collective agreement with the RNAO and by their failure to adopt or adhere to any portions of the recommended RNAO salary scale except where market considerations force them to do so. This remains the case despite a shortage of nurses.

How this situation can be overcome — assuming that this would be desirable — is the challenge before you. Unless you are prepared to trust the "invisible hand" (Adam Smith's apt description of the interaction of the unseen forces of supply and demand), to see to your professional welfare, there may be only one answer. Despite its potential shortcomings, somehow you may have to prevail on the provincial government to grant you the right to take your employers to arbitration. The fact that the government has already conceded this right to policemen and firemen and is planning to give the same rights to its own employees suggests that it would be hard-pressed to deny you a similar opportunity.

BASIC QUALITIES OF A GOOD NURSE

RUBY ROGERS, B.SC. and WILMA BALLANTYNE

Only by retaining certain attitudes and qualities will the practitioner be capable of meeting increased nursing responsibilities.

With the many changes recently proposed in the education of a nurse, it seems timely to consider those qualities which we cannot afford to lose — qualities that are part and parcel of every good nurse. In this study, an attempt has been made to define these qualities, to identify the philosophy that motivates the actions of a good nurse, and to discern how this way of thinking and acting is internalized by students.

This article was prepared by a special committee of the Nurses' Alumnae Association of the McKellar General Hospital School of Nursing, Fort William, Ont. Miss Ballantyne acted as chairman of the committee, and Miss Rogers, Director of Nursing, wrote the final draft.

A Patient-Centred Approach

Patient-centred is a term that is used frequently in both nursing service and nursing education circles. What does it really mean? Simply that the needs of the patient influence and guide all of the nurse's actions. This concept of care not only prompts the practitioner to give her patient a glass of water, but dictates the manner in which the water is offered. It permeates her so thoroughly that she becomes sensitive to the patient's every mood and recognizes whether he is best served by attention to physical needs, or more

than anything else, whether he requires a sense of security and peace of mind. Often, by a gesture or an encouraging attitude, the nurse can answer the unspoken question and can quiet the unvoiced fear. In times of stress, even the most irreligious feel a necessity for assurance and hope. A nurse can often help to meet these needs — not necessarily in words, but in the solid basis of realism, hope and confidence which her experience in nursing has given her. This realistic hope and confidence is expressed in manner and gestures as well as in words. It is only through being thoroughly patient-centred that she can develop: skills to understand and care for patients of various age and ethnic groups who face different crises; an awareness of the support needed when the patient is really sick and of the gradual need for him to become independent.

Because of her absorption in the patient, the nurse is able to observe a change in his condition before it is revealed by signs such as blood pressure, temperature and pulse. This has long been a recognized attribute of a good nurse. With increased reliance on signs of a mechanical nature, this ability is in danger of being lost. Since the nurse is with the patient longer than any other member of the health team, she is the person best qualified to observe these changes. Whether it be observation of danger signals or of mental and emotional stress, the nurse who has not learned to become really patient-centred will have difficulty performing these important functions.

To the average layman, many of the nurses' tasks seem menial, dirty and repulsive. Emptying bedpans, changing malodorous dressings, etc. are usually viewed with great repugnance. This attitude makes it all the more imperative that the nurse performs these intimate services with dignity, sympathy and tact so as not to hurt the sensibilities of the patient. Any sign of distaste on her part adds to the patient's mental distress. Since these things are important to the patient, and since the manner in which they are performed is equally meaningful, the nurse accepts them as a professional and not a menial task.

A nurse who gives patient-centred care will not only be concerned with how her patient is today, in hospital, but also with where he is going tomorrow, when he leaves hospital. In order to assess the situation before he leaves, she must have a clear understanding of his present home and family situation. All this is included in total patient care.

In the past, when the student nurse was used primarily for service, there was no doubt in her mind that the patient came first — before her education, even her health. She suffered in her professional development, since the academic part of her education was neglected; she suffered in her development as a person and as a citizen since service demands conflicted with outside interests. Today, there is danger, in the well-organized and well-rounded education of a nurse, that the patient will hold a secondary place in her education. If she is taught that something pertaining to her — even something as important as her own education — comes before the patient's welfare, then how is she expected to put the patient's needs first when she is a practising nurse? It takes careful planning on the part of those in charge of schools to see that the student is never put into the position of making a choice between her patient and her classes — with a penalty imposed if she is late for class.

The present philosophy of society is centred on self. It takes time, and repeated, continuous exposure to change a self-centred girl, emerging from adolescence, into a patient-centred nurse. This change is not academic; it can only be learned by experience and practice.

Residence life for nurses has been an influential factor in this reformation of character. How could a change of outlook be accomplished if the student nurse were continually in contact with those whose primary aim was to learn to make money, instead of to consider the well-being of others? If persons within our society were to become "other-centred," the nursing student would already have internalized this attitude. This is, unfortunately, not the case. In residence, if only for a year or two, the girl is surrounded by those whose aims are the same as hers. She,

therefore, more readily accepts this new standard of behavior.

This concern for people is an exciting and rewarding experience. The danger is that the nurse finds her work so absorbing and rewarding that normal recreational pursuits seem dull in comparison. With increasing salaries, the nurse has more opportunity to find suitable recreational outlets. This is essential because a narrow person, withdrawn from the community, will not remain a good nurse. Nursing demands so much of the whole person that a nurse needs to be a well-informed, active individual, with sufficient relaxation and change to maintain perspective and judgment.

A Sense of Responsibility

Nursing responsibilities are increasing. The medical profession tends to delegate to the nurse, more and more technical procedures — procedures that were once considered too skilled or too dangerous for her to perform. With the proliferation of kinds of medicines manufactured and ordered, the unsystematic naming of medicines, and the numbers of different trade names listed for the same medicine, this area holds many pitfalls.

Changes in patient care have also increased the nurse's responsibilities. Her judgment is being continually exercised as to how long a patient can stay up, how much he should be encouraged to do for himself, etc. Health teaching is more concentrated because of the shorter hospital stay for many patients.

The good nurse accepts all of these responsibilities and more. No aspect of care is overlooked, whether it is the diet slip that must be completed, the laboratory requisition that must be signed, or care to the patient's back. She makes sure that the doctor signs an order and that the physiotherapy department carries out its part of the treatment. One can question the justice of this, but one cannot question its benefit to the patient.

How is this acceptance of responsibility developed? Basic to it, is the concept of service to the patient. The importance of the work is stressed; the dangers of giving a wrong medication are emphasized so that the infrequent errors are reported. At first, the student is closely supervised. As her education progresses, she is allowed to function with less. She is given further responsibility when she has demonstrated that she can perform the work well and has acquired attitudes and reactions that can be trusted. It is not easy to work under close supervision, but it does instill, in the mind of the learner, the importance of the work and her responsibility to those in her care.

It is of the utmost importance that this quality of individual responsibility be retained, since so much of the work is done without direct supervision. Who is to see if she does not measure the medicine accurately? Who will know if she breaks technique while caring for a patient with an infectious disease? Only each nurse's own sense of responsibility for the patient's welfare can maintain a high standard of care.

A Non-discriminating Attitude

The nurse tends to regard people in a different way than others do — in terms of how well they stand pain, of how patient they are, or of how cooperative they are in following orders and taking treatment. Whether the patient is wealthy or poor, whether he is highly intelligent or of below average intelligence is of little importance to her. Since status does not rank high in her sense of values, and since patients rarely have important status symbols with them in hospital, these things have little bearing on the regard that she has for a patient.

The good nurse tends to be realistic. She is aware of the strong and weak points in a patient's character but refrains from passing judgment. She recognizes the similarities in patients — their basic mental and physical needs. She also recognizes the individual differences in people. She endeavours to understand and adjust her care according to these differences, without being critical. The patient's family and friends help her to understand the patient and his problems, but they do not affect her regard for him. This regard for each individual is evidenced by the great variety of people that a nurse calls "friend."

In some ways, this may be the easiest lesson for a student to learn. It is impossible to exert great effort to save a life and then regard that life as of little value. It is learned that all life is of value, and the differences in the attributes of a person should have no bearing on the nursing care that he receives. It is the essential dignity of a human being and his right to live that is important.

The student nurse learns to value the services of all those with whom she works and to appreciate the people who perform these services. The importance of cleanliness gives significance to the housekeeping staff who are responsible for this. The student is taught to be considerate and to try to lessen work for the cleaners or for anyone else whose work contributes to the well-being of the patient. This is easily learned since the nurse may have to take over the duties of cleaners, porters or clerks on evening and night tours of duty. She thus recognizes the worth of all people, whatever their status.

This equal regard for the worth of all people is a priceless heritage that nursing cannot afford to lose; nor can society afford to see the care of the sick dependent upon the status of the person who is ill. This is the true equality of man — not of wealth, intelligence, goodness, or badness, but in being human and, therefore, worthy to be kept alive. This is the wisdom of nursing: to recognize the differences in order to assess the individual problem, but to regard each patient as equally worth her best efforts in nursing.

An Altruistic Motivation

It is impossible to put the patient's needs first and at the same time demand things for oneself. One cannot serve two masters. That nurses have had this quality — of considering their patients before themselves — is evidenced by instances of inadequate salary, in spite of the shortage of nurses. When a shortage of laborers exists in any field of work, the pay goes up accordingly — unless the laborers value service to others more than their own ambitions. Until recently, the salary for nurses came from one source — the patients. Only with the advent of government hospitalization insurance has this, indirectly, ceased. Many nurses have considered it impossible to worry patients about paying bills which were incurred while they were making every effort to restore them to health. They did not fight for raises in salary with any conviction or energy.

Employers have taken advantage of this attitude as evidenced by the relatively small salary the nurse receives and the services she is expected to give. It has been a tradition that a nurse would do any work that was important to the welfare of the patient. Thus, it has been a temptation, to many, to load more and more work onto her shoulders. Often what was important to the patient has been broadened into what is important to *hospital administration*. The danger is that the nurse will have no time left for the care of the patient. Even now it is questionable how much direct care the patient actually receives.

How has this attitude of giving service rather than receiving recognition and remuneration been developed in the student nurse? It results from her training in putting the patient and all that pertains to him first. Being taught the importance of cleanliness to her patient, she accepts the idea that cleanliness must be maintained, even if *she* has to do the cleaning. By learning respect for the medical profession and obedience to the doctor's orders, she learns to take orders and to carry them out meticulously. This respect and careful obedience is sometimes mistaken for subservience.

How do we encourage the nurse to continue to emphasize service rather than recognition? How do we protect her work from being hindered by the inclusion of too many non-nursing duties? An examination of the field of hospital nursing, and careful analysis of the problem is necessary.

Studies undertaken by the nursing consultants of the Ontario Hospital Services Commission, have made a notable contribution toward the assessment of the role of the hospital nurse. Regardless of how nurses are educated, the largest employers of nurses are hospitals, and these will continue to provide a large part of the student's clinical experience. The hospital nurse's

role is a subject that must concern those responsible for educating the nurse, as well as those responsible for her work in the hospital. When a good assessment of the role of the nurse in the hospital has been made, steps must be taken to make that role more conducive to the giving of good nursing care. This entails education of hospital authorities so that they will recognize the value of good nursing care and the waste and extravagance of using nursing personnel for other services. It will take courage on the part of leaders in nursing and especially those involved in nursing administration. These persons are in a position to fight for the nurse and her work. Since the nurse administrator is directing, rather than doing the bedside nursing, she can afford to fight for the work of the nurse, without sacrificing patient care. She can fight for the right of the nurse to have *time to nurse* and can help in the planning of the hospital organization to meet this end.

Nursing administration and nursing education must work together to support the graduate nurse in the hospital so that good nursing care will be given and the community and the nurse will be well satisfied. Professional nursing associations, directors of nursing and all others in the hospital field can fight for proper remuneration and status for the nurse so that she is free to concentrate on service.

Rapport with the Patient

Rapport implies a sense of trust and empathy between patient and nurse. It is expressed by the patient's confidence in the nurse's ability, knowledge and skill, and in her sympathy, understanding and concern for his welfare. It is also expressed by the patient's concern for the welfare of the nurse. This mutual concern is of great value to the patient as it directs his thoughts to someone outside himself. In a patient who is convalescing, this is an important step in preparing him for a resumption of full independence and a return to the responsibilities of his normal life.

Rapport is established while doing things for the patient — by rubbing his back, bathing him, etc. In this way, a sense of intimacy is developed. The physical contact of a nurse and her patient might be likened to a baby's need to be held. It sets the scene for greater confidence and an opportunity for psychological support and health teaching. By repeatedly performing these manual tasks, the student learns skill in doing them and in assessing the degree of success she is having in giving comfort.

People who are cold and unsympathetic cannot tolerate physical contact with other people. Actual physical contact seems to call forth a warmth of regard that the cold person is unprepared to give. It is a further means of communication between patient and nurse — communication by sense of touch as well as by seeing and hearing. Just as nurses learn to speak in gentle tones, to guard their expressions and attitudes, so also do they learn to use skill in handling patients, so that the touch of their hands communicates the sympathy and understanding.

This is an important aspect of nursing. It is essential that the student of the future have this opportunity to develop rapport between herself and the patient. No matter how much emphasis is placed on psychological skills, the physical skills of nursing must be maintained. A nurse who lacks these, will not attain rapport with her patient. Hours and hours of sitting and talking at the patient's bedside will not gain his confidence like half an hour of physical care. To try to establish rapport by sitting and talking, is a little like faith without works.

The Nurse As a Liaison Officer

It is the combination of all the foregoing qualities, with the addition of self-control and self-discipline, which makes it possible for the nurse to act as an excellent liaison between hospital personnel, the patient and the different departments in the hospital.

It is the nurse who transmits the doctor's requests to the other services and often interprets and clarifies. It is often she who explains the doctor's orders to the patient himself and, again, who sees to it that the patient understands the x-ray procedure, the operation to be performed or the laboratory test to be done. Because she is "patient-centred," everything that

concerns the patient concerns her. X-ray is interested only in what concerns the taking of the x-ray; the physiotherapist is interested only in that part of the patient which he is treating. The nurse is interested in all that concerns the patient — in the treatment itself, the outcome of the treatment, and the patient's reaction to it.

Equal regard for the worth of all people, regardless of status, makes it possible for the nurse to communicate with ease to whomever she is talking, be it a very intelligent person or a person of little wit or education. Thus, she can get the cooperation of the porters as well as the radiologist. It also makes possible the liaison between the nurse and clergy, regardless of creed, since all faiths are given equal consideration.

Emphasis on the service given rather than the remuneration received or the status or prestige obtained is essential for the type of liaison work in which the nurse is involved. If she had great concern for her prestige, would she be able to take it calmly when the x-ray technician reprimanded her because the doctor had not provided the department with a patient's history? If prestige had been her concern, she would have been more anxious to exonerate herself rather than to provide the information and get on with the work. Even now, it is hard for the nurse to be too concerned with certain administrative paper work and record keeping, but if she were concerned about status, she would really give a rough answer to the record clerk who came to reprimand her about some omission. It is because she puts service before prestige and remuneration that she can handle all these different people and keep a sense of balance.

Personnel in other departments do not usually attempt to prepare the patient for a treatment or test but expect the nurse to do it. Administration places an equal responsibility on the nurse, expecting her to gain the patient's acceptance for hospital rules and regulations. It is the nurse who is expected to deal with the visitors, in a way that will support the hospital's policy regarding visiting hours and still maintain the good-will of the public.

All these qualities help the nurse to fulfill the role of liaison agent in the hospital and between the hospital and the public. It is a big job. Without the addition of self-discipline and self-control, it could not be done. It would be impossible for the nurse to restrain her own feelings when unjustly accused of something, if she had not learned to practise self-control. This discipline is, in part, a product of the demands of her profession. The patient's needs leave no room for weakness on her part. Others can be forgiven and understood if they have outbursts of temper. In fact, it is not uncommon for the surgeon to take his bad humor out on the nurse. Others are thus privileged in various ways and degrees, but the nurse is severely criticized if she speaks sharply or crossly to an employee or dares to be rude to a record clerk. She is expected to remain calm and in control of the situation so that she can give support to the patient and pour oil on any troubled waters. She is expected to be able to accept the bad temper of patients, doctors and, sometimes, her superiors in the nursing service.

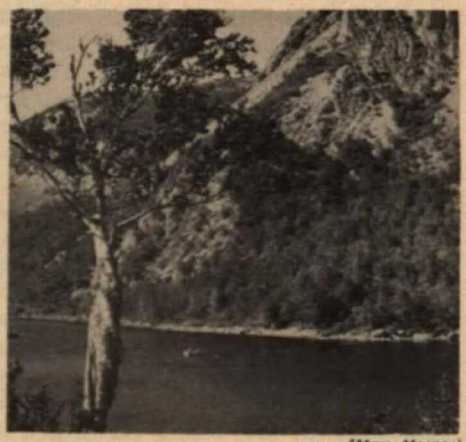
It may be unfair to demand that a nurse have this discipline, but it is essential in liaison duties, as any good diplomat knows. Because of her concern for the patient, which overrides her personal feelings, she manages to rectify errors, cool the wrath of other departmental personnel, and regain good relationships with all very rapidly. No one but a nurse could perform this function so efficiently. It is important that she continue to act in this capacity because no one else can do it as well! No one else has the patient's confidence to the same extent; no one else has the calmness and singleness of purpose. Others have wondered how the complex, varied departments in a hospital work so well together. They would not work so well if the nurse were not standing by ready to take the butt of frayed tempers and to see that all the detail is done. Nor could anyone else do the work as economically as the nurse. Only she has sufficient knowledge and understanding to act as liaison in this fashion. How would the hospital function if the nurse were not the liaison between all departments and the patient?

THE WORLD OF NURSING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

Convention Fever

Since the day that the ARNN's "Invitation to Newfoundland" was accepted by the Executive and members of the CNA, the nurses of Canada's youngest province have been caught up in "convention fever." It would be difficult, indeed, not to catch their fever, as we in National Office can well attest. We know how they have been steadily paving the way for nurses of their sister provinces to enjoy the best convention ever when they meet in St. John's next June. If enthusiasm alone guaranteed success, the 32nd Biennial Meeting could not miss. But, unfortunately, it takes a great deal more. We all need to pitch in and contribute to the over-all success of the conference and there is no better way than by planning to be there **June 14-19, 1964.**



(Max Mercer)

A tranquil scene on the Humber

Those who have not yet visited Newfoundland should enquire of their friends who have ventured East about this land of scenery without parallel for beauty and variety and about the hospitality and charm of its people. Old world atmosphere that has been preserved through the centuries will surround you throughout your stay in St. John's. Nowhere else in the world could you find so much history in such a small area. The city is one of the oldest in the new world; it is built on a hillside overlooking a magnificent harbor. Here, Memorial University with its spacious new campus will provide the setting for the 1964 convention of Canadian nurses from coast to coast.

Of course, atmosphere and hospitality alone are not sufficient reasons for you to head East, but they are offered to you in the course of your work. The Biennial Meeting itself is most important for it is here that policy affecting all phases of nursing will be made. It is here, too, that you will be able to give your views on nursing, hear the views of others, and carry away thoughts that will be worth re-

(Lee Wulff)

View of St. John's

membering. The exchange of thoughts, the pooling of ideas and the study of solutions are the essence of the convention.

For months now PRESIDENT ELECTA MACLENNAN and her committee have been working out a program that they feel will give purpose to each one attending. It is now going into its final stage; you will be able to have a look at it in December's issue along with some of the highlights of the convention. Give a good look, then make plans to go East in June.

The nurses of Newfoundland look forward to making your stay one of the most pleasant you have known in the Association. Can you resist their invitation?

(Newfoundland Tourist Development Office)

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Crossed Eyes

H. WYATT LAWS, M.D.

The modern approach to treatment

Following World War II, the majority of children seen by ophthalmologists for treatment of crossed eyes (strabismus) were four years old or over; many were over ten. After an intensive educational program aimed at general practitioners, pediatricians, interns, medical students and nurses, it became a rarity by 1955 to see cross-eyed children over the age of four. Most were arriving in the ophthalmologist's office at the age of two, as advised. As a result of new knowledge and better understanding of the science of treating strabismus, ophthalmologists now want to see these patients as early as six to nine months of age.

Nurses hold a position of major importance in the education of the general public. The purpose of this article is to present them with the scientific reasons behind this recent change of attitude.

By the age of six months, the reflexes that control binocular fusion in all directions of gaze, and the central vision areas of the retinae (the maculae) are developed. If they are correctly related and balanced, there is development toward stronger, accurate and more fixed relations. If, however, they are incorrectly related, this faulty relationship becomes stronger, more fixed and less curable with advancing age. By the age of five, the reflexes, whether correct or incorrect, are established for life. Approximately 50 per cent of this development is completed by the age of one year. After this time the percentage of good results in treatment of crossed eyes falls rapidly.

Dr. Laws is Ophthalmologist-in-chief, Queen Elizabeth Hospital of Montreal, and assistant surgeon, Department of Ophthalmology, Montreal Children's Hospital.

There are other reasons why children with strabismus should be under medical observation early in life. Multiple eye diseases, such as infantile glaucoma (curable if diagnosed early), and cancer of the eye (retinoblastoma) which can frequently be cured without removal of the eye if discovered in the early stage, must be taken into consideration. This latter condition is frequently fatal to life as a result of metastases, if seen too late. These conditions, since they produce poor vision in one eye, usually cause the blind or semi-blind eye to turn *in* under the age of two and to turn *out*, if onset occurs over the age of two.

If the eyes remain crossed, in order to avoid seeing double (diplopia) the brain will do one of two things. The most common reaction is to suppress the image of one eye and use only the eye that sees most easily, that is, which has the least refractive error. This results in lack of development of the brain area for sight emanating from the unused eye. If not corrected early, there will be permanent loss of practical vision in this eye (*amblyopia ex anopsia*). The second possible reaction of the brain occurs rarely and is usually associated with eyes of equal visual potential. Here, alternating suppression occurs in which one eye is used at one moment, the other the next, but never both simultaneously. Stereopsis (depth perception) is, of necessity, lacking in both forms of adjustment and in the case of amblyopia the individual faces the life-long hazard of accidentally losing his one good eye and being reduced to semi-blindness.

Eligibility for employment in the presence of amblyopia is seriously reduced. In the absence of stereopsis, it is also considerably lessened because insurance rates for employees without

depth perception are about 17 per cent higher than for those with normal vision. Hence, many large companies refuse to employ those so handicapped.

In addition to loss of vision in one eye, and lack of stereoscopic vision, a third very important problem is associated with crossed eyes. This is the psychological trauma that a child is invariably subjected to by his playmates who quickly make him realize, with the term "cock-eyed," that he is different and less desirable. Usually he responds by developing an inferiority complex, although the occasional child will compensate by becoming objectionably aggressive. The fact that in later life others are embarrassed by his appearance frequently keeps him from being considered for senior business positions.

Delay in Treatment

Why are children still going to ophthalmologists too late to obtain the best results from treatment? There are many possible reasons. Parents may have been told by the family doctor to wait until just before the child enters school. The general practitioner is swamped with new material in every field of medicine; it becomes increasingly difficult for him to keep completely up-to-date. Relatives or friends may have advised parents to wait and see if the condition would correct itself. Some parents have the erroneous idea that early treatment may be dangerous or they dislike seeing "such a little baby" subjected to surgery. In some cases where the angle of turn is small, parents become so accustomed to their child's appearance that they fail to realize that the eye is crossed and neighbors and friends are frequently reluctant to tell them. Some parents deny their children the attention of an eye physician for religious reasons or false pride until the child himself forces the issue at puberty or, upon reaching the age of 21, seeks medical advice without parental consent. Some parents take their strabismic children to optometrists. It is very difficult for the optometrist to gain an accurate idea of the child's refraction since he is legally forbidden to use necessary medications (atrophine or homatropine drops, etc.). Unfortunately, many optometrists have shown an unwillingness to refer such cases to eye physicians. Parents may have gained the erroneous impression that optometrists, who frequently use the prefix "doctor," have been medically trained. When he does not advice surgery, they assume that they have had a medical opinion.

Associated Conditions

A crossed eye that turns inward (convergent strabismus or esotropia) is frequently associated with a focus point that is beyond the horizon (hypermetropia or far-sightedness). This condition requires strong magnifying lenses, but these in themselves will only cure an extremely small percentage of patients. Usually a minor operation is required to slacken the in-pulling medial rectus muscles. The operation does not interfere with vision; these muscles are outside the eyeball and the procedure is in no way dangerous. Unless the operation is carried out at a very early age in such a way as to establish parallel eyes, normal development is unlikely to occur.

A crossed eye that turns outward (divergent strabismus or exotropia) may occur in combination with far sightedness, short-sightedness, or in eyes that require no glasses at all. This condition is much more insidious. In the early stages, it appears only when the child is not concentrating or is looking dreamily off into the distance. This phase usually occurs between the ages of six months and one year. If untreated, the condition *apparently* improves for a period of from one to two years. Actually, faulty development continues insidiously and is followed almost inevitably by an obvious increase in the degree of exotropia. At this stage it is too late to obtain the best possible results from corrective measures. The muscles that pull the eye outwards (the lateral recti) have to be relaxed. Again the operation is performed outside the eyeball, does not affect vision, and is not dangerous.

Eye muscle exercises (orthoptics) are frequently of value immediately before operation in order to prepare

the brain for the oncoming procedure. Immediately following operation orthoptics assist the brain to adapt to the new position of the eyes. Apart from these circumstances, orthoptic procedures are of no value; hold no promise of curing a crossed eye; if employed in a patient with alternating suppression may result in permanent double vision (diplopia). Orthoptics should never be employed without supervision of an ophthalmologist.

Advice to Parents

What advice should nurses give parents? All children with crossed eyes, whether actual or suspected, occasional or constant, should be seen by an ophthalmologist between the ages of six and nine months. Where there is a known family history of strabismus or where either or both parents have worn glasses under the age of 20, all children, even though they appear normal, should have an ophthalmological examination. Family economics should be no deterrent. Free clinics, staffed by well-trained ophthalmologists, who give their time without remuneration for the less fortunate in the community, are provided by most general hospitals.

Personnel

Considerable confusion arises out of the multiple terminology applied to those associated with care of the eyes. The *optician* is a highly trained technician and an expert in fitting and making glasses. He does not test eyesight; he is not a physician. The *optometrist* (eye sight specialist) is trained to test the eyes for glasses, that is, to perform a refraction. Some optometrists have had limited training which enables them to recognize the commoner eye diseases but does not qualify them to prescribe treatment. It is their duty to send such cases to an eye physician. Some optometrists are also opticians. The term O.D. following the optometrist's name stands for Diploma in Optometry, not Doctor of Optometry. The *ophthalmologist* is a physician who has had an additional four years of experience in eye surgery and the treatment of eye diseases. He is fully qualified to perform eye surgery. He diagnoses and treats all disorders of the eye including, among many others, strabismus, cataract, defects of focus (near-sightedness, far-sightedness and astigmatism), glaucoma, tumors, disorders of the eyelids, etc. He prescribes glasses where indicated, and is the only person qualified or legally licensed to use eye solutions during the examination prior to prescription. The use of such solutions is extremely important, especially in young children, since it is the only accurate way to arrive at a correct estimation of the need for glasses.

Summary

All children actually or potentially cross-eyed should be seen by an ophthalmologist between six and nine months of age.

The ophthalmologist has a threefold goal in the treatment of strabismus: Normal vision in each eye; stereoscopic vision; cosmetically straight eyes.

A recent Gallup Poll indicates 82% of Canadians think a satisfactory Medicare plan could be worked out between government, patients and doctors. The 11% who thought Medicare unworkable gave as reasons the doctor's opposition to state medicine, fear of increased taxes and dislike of government control.

— *Ontario Medical Review*, vol. 30, May 1963.

Nurses who are interested in receiving circulars concerning the medical services and the health situation throughout the world, should write directly to: Miss P. Vachon, Publications Branch, Queen's Printer, Ottawa, Ontario.

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There is nothing more tragic in life than the utter impossibility of changing what you have done. — JOHN GALSWORTHY

Nursing Profiles

On January 1 of this year, the College of Nurses of Ontario came into official being — the first organization of its kind in Canada and possibly in the world. Hereafter, the province's 50,000 registered nurses and certified nursing assistants must be registered with the College in order to practise. Its first director, **Jean Cockburn Watt** who has been deeply involved in the development of the College from its earliest inception, was appointed in July. To her

(Joseph Schmid)

JEAN C. WATT

new duties she brings a wealth of experience garnered from 11 years as a member of the executive staff of the Registered Nurses' Association of Ontario and many long days of painstaking research and study as secretary to the working party that laid the foundation for the College. Prior to her present appointment she served as administrative assistant to the provisional council of the new organization.

A graduate of Victoria Hospital, London, Ont., Miss Watt studied public health nursing at the University of Toronto. She is a former staff member of the Victorian Order of Nurses and of the Township of York, Ont. health unit where she served for six years as nurse in charge. The war years, 1942-45, were spent in service with the RCAMC overseas. Miss Watt remained on in Germany for an additional two years as nurse and area nursing supervisor with UNRRA. IN 1952 she joined the RNAO as membership secretary and later became public relations secretary.

Also named to executive positions with the College were **Patricia S. B. Anderson** and **Albert Wedgery** who will serve as assistant directors. Miss Anderson, a graduate of the Hospital for Sick Children, Toronto, and of the University of British Columbia, is a former inspector of schools

JEAN CUTHAND

of nursing, Ontario Department of Health. Her functions within the College will be related to professional standards. Mr. Wedgery, a graduate of the Ontario Hospital, Whitby, is a former member of the executive staff of the RNAO and of the Oshawa General Hospital staff where he served for several years as nurse, nursing instructor and supervisor. He recently completed requirements for his Master of Arts degree in nursing administration from Columbia University, New York. His present duties

will be related to business administration.

The appointment of **Jean Cuthand** as executive director of the Indian and Metis Friendship Centre, Winnipeg, climaxes a story of a struggle for recognition. Miss Cuthand, a Cree Indian from Saskatchewan's Little Pine Reserve, is the first girl of Indian origin to graduate from the Holy Family Hospital, Prince Albert, Sask. To achieve her desire to be a nurse, she determinedly braved discouragements and hardships that for many others would have spelled failure.

Once graduated, she embarked on a successful nursing career that ranged from an Indian and Northern Health Services nursing station in La Ronge, Saskatchewan to staff duty on the wards of King Edward VII Memorial Hospital, Hamilton, Bermuda. Her experience in La Ronge carried heavy responsibilities since the village lacked a resident doctor and her only assistant was a nurse's aide. Her ability to speak Cree proved a particular asset in this situation.

(Ashley & Crippen, Toronto)

LUCILLE SCORER

After her return from Bermuda, Miss Cuthand spent much of her spare time at the Indian-Metis Friendship Centre, Prince Albert. Last fall she initiated the Indian-Metis Youth Club — the first in Saskatchewan. Until her Winnipeg appointment, she acted as senior advisor to the Indian and Metis teenagers who made up its membership. Now she has laid aside her nursing career to take up one that has significance for Canadians generally — helping to bridge the gap between two cultures and to achieve for others of Indian origin a "place in the sun."

The Regina General Hospital recently announced the appointment of **Lucille Margaret Scorer** as director of nurses. A graduate of the Children's Hospital, Winnipeg, Miss Scorer completed requirements for her B.Sc.N. from the University of Toronto in 1962. Her experience following graduation carried her far afield to George Washington University Hospital, Washington, D.C.; Babies Hospital, Newcastle-on-Tyne, Eng.; Queen Elizabeth Hospital for Children, London, Eng., and finally back to Winnipeg and The Children's Hospital where she served as Central Supply Room supervisor and later as assistant director of nursing service. Most recently she was a supervisor on the staff of Toronto General Hospital.

HELEN PENNY

Helen Dorothy Penny has just completed her first year as director of nursing, Central Newfoundland Hospital, Grand Falls, Nfld. A graduate of the General Hospital, St. John's, Nfld., she studied public health nursing at the University of Toronto and returned to her hospital to become health instructor in the department of nursing education. In 1957 she was appointed associate director of nursing service, S.J.G.H., a position she held to the time of her present appointment. During World War II, she served with the Women's Division, RCAF as an aerial photographer.

A past president of the St. John's chapter ARNN and past chairman of the provincial association nursing service committee, she is presently a member of the CNA Committee on Legislation and Bylaws. While in St. John's Miss Penny served on the local VON board of management.

Monique C. Deslieres has been awarded the 1963-64 nursing bursary of the Canadian Red Cross Society. A graduate of Notre Dame Hospital, Montreal, she had three years' experience in industrial nursing with the Canadian British Aluminum Company, Baie Comeau before joining the Canadian Red Cross Society. She has been the nursing supervisor of the blood transfusion service depot, Quebec City.

Miss Deslieres intends to study public health nursing at the University of Montreal and she hopes to become an outpost nurse following completion of her course.

In Memoriam

Helen Louise Randal (Royal Victoria Hospital, Montreal '03) died in Winnipeg in August, 1963. A former superintendent of nurses of the Vancouver General Hospital, she helped to organize the Graduate Nurses' Association of B.C. and served as its first president 1917-19. When the Act for Registration of Nurses in the province was passed in 1918, Miss Randal was appointed registrar and inspector of schools of nursing. She carried out the duties of these offices until her retirement from nursing in 1941. A former president of the Canadian Society of Superintendents, she also served as editor of *The Canadian Nurse*, 1916-24 — the first editor of the *Journal* following its purchase by the Canadian National Association of Trained Nurses (now the CNA). In 1958 a debt of gratitude to Miss Randal for her many years of loyal service to her profession was acknowledged when honorary membership in the CNA was conferred upon her. She was 91 years old at the time of her death.

* * *

Ruth Lorine (Kilmer) Beaulieu (St. Thomas-Elgin General Hospital, St. Thomas, Ont. '58) died in May, 1963.

* * *

The alumnae association of the Vancouver General Hospital records the death of these graduates: **Lady Margaret Syrea (Strachan) de la poer Gough** '21 and **Dorothy Irene Wittmayr** '28.

* * *

Myrtle Irene Ellis (Women's College Hospital, Toronto '23) died on June 10, 1963 in Toronto. She was a former staff member of the Red Cross Outpost Hospital, Englehart, Ont., St. Mary's Hospital, Timmins, Ont., and had nursed for many years in Iroquois Falls. Most recently she had engaged in private nursing.

* * *

Laura Filion (Sainte-Jeanne D'Arc Hospital, Montreal '46) died in Montreal on June 2, 1963.

* * *

The alumnae association of Winnipeg General Hospital records the death of the following graduates: **Florence M. Harrison** '18 in Alhambra, California, after a long illness and **Ellen E. Love** '15 in Ariss, Ont., after a long illness.

* * *

Bessie M. MacMurchy (Montreal General Hospital '31) died in London, Ontario on June 16, 1963. She had nursed in India for over 30 years, her most recent position being director of the Graduate School for Nurses, Indore. Miss MacMurchy was home on furlough in order to complete requirements for her Master's degree in nursing science from the University of Western Ontario.

* * *

Florence E. McCabe (Nova Scotia Hospital, Dartmouth) died in Montreal.

* * *

Grace A. K. Moffat (Royal Victoria Hospital, Montreal '21) died on July 31, 1963. Formerly director of nurses at Chipman Memorial Hospital, St. Stephen, N.B., for many years she was on the staff of the nursing school office, RVH. She was in her 79th year.

(Continued on page 977)

JOHNNY - A DELINQUENT

LOIS J. FORD

Juvenile delinquency occurs with increasing frequency in our country. When racial prejudice contributes to its cause, a formidable problem presents itself.

At the back of the grade nine classroom, Johnny sits alone. In the gymnasium and in the park, he plays alone. On the street, he walks by himself — always alone. Why? Do the other children scorn his Indian heritage and dusky skin — or are they afraid of him, of the hostility he displays with every gesture? Do they see those disillusioned eyes, so hard yet so unhappy? Do they wonder *why* Johnny is so unfriendly?

To the townsfolk and to the law, Johnny is a delinquent — a child who has broken society's rules and regulations. While other boys have learned to play football, he has learned to steal — to steal slyly and well. While other boys watch trials on television, Johnny participates in them. Other boys try to picture the inside of a reform school; Johnny has no need to wonder — he already knows. At the age of fourteen, he knows!

At school, Johnny's maladjustment had not escaped notice. He was sullen, insolent, and discourteous to his teachers. Frequently late and more frequently absent, he would force other pupils to recopy the notes that he had missed. Girls were afraid to walk ahead of him on the stairs and would turn sideways to keep his every action in view.

INFLUENCE OF ENVIRONMENT

The people of the town attributed Johnny's delinquency to "bad blood." Constitutional factors were not, however, the cause of his antisocial behavior. Nor was mental deficiency an excuse for Johnny's misdeeds. Examined by Dominion Omnibus and Otis Intermediate test forms, he was assigned an intelligence quotient of 117 — above average. Indeed, were he to become an adult lawbreaker, he could make a very successful career of crime.

J. M. Hunt, in a study of behavior disorders, attributes their main cause to the nature of early experience, especially emotional relationships.[1] As a child, Johnny lacked close primary group relationships. Excluded from the world of both his Indian mother and his German father, he was unable to claim identity with either race. Living among white children, he was not one of them. They laughed at his brown skin and black eyes. A happy family life might have given him the security he needed, but his parents were never home — both of them worked. A Boston judge once said: "Father on the day shift, mother on the night shift, children on the street shift."[2] So Johnny and his three brothers and sisters roamed the streets. Drunken brawls made home a dangerous place; blows fell on any child unlucky enough to be caught underfoot.

Frustrated and insecure as a child, Johnny grew up to be an aggressive and hostile youth. Striking out at an unfair world, he found himself labelled "juvenile delinquent." People didn't understand — so he didn't care! He built up a shell and always walked alone.

WHOSE RESPONSIBILITY?

Many groups and organizations of the town might have helped Johnny although they never considered *his* problem was *theirs*. Perhaps they did not realize that 20 per cent of all

Miss Ford was a second year student in the basic degree course, University of Toronto School of Nursing, when she wrote this article. It tied for second place in the Macmillan Award Competition this year.

crimes are committed by children.[3] Perhaps they just did not care. Johnny's family had no church but the town had many. These churches were proud of their young people's groups and of their church schools. Not one of them, however, tried to reach the boy who most needed their attention.

Johnny's frequent absenteeism from school, forced the principal to take action. When the boy did not appear for class, he would phone the truant officer who would find Johnny and escort him to school. The Children's Aid Society warned the parents that unless their discipline and care for the child improved, they would lose their children's allowance from the government. The Society questioned whether or not Johnny should be removed from his home. Such a step had to be considered carefully since it is in the home during childhood that the pattern of lasting friendly emotional relationships is established.[4] The social worker thought that possibly the parents could be counselled and helped to change their ways. During interviews, they seemed to want to help — at least until they got home. The Children's Aid was concerned with many children and had so few homes in which to place them. Johnny had food in his stomach and clothes on his back — even if that back had bruises from a drunken father's blows. It was decided that he should remain at home.

In the playgrounds, Johnny was a nuisance. Other children were afraid of him. Parents complained that he should not be allowed to play with "decent" girls and boys. Nevertheless, when he was younger, the park commission had done a great deal for him. He played soccer, swam and was barker at the penny carnivals. When he grew older he lost interest in this "child stuff," and, besides, the parks were only open during the summer months.

Johnny received little help from the police. They frequently brought him home at night — home to a family torn by dissension. They said they wanted to help, but they never smiled or made an effort to befriend him. They caught him stealing cash from a store, but were unable to convict him on the available evidence. After the judge at Children's Court pronounced him not guilty, Johnny prepared an essay for a school assignment entitled "It Was Fun While it Lasted," in which he described his exciting day at court. The last sentence echoed his feelings about policemen: "I think that Jack — the cop who thought I would get reform school—really got cheezed off."

The teachers wanted to help Johnny, but sometimes they used the wrong approach. Frequent strappings only served to increase his hostility. The principal befriended Johnny. He spent extra time with him and assigned him work that he could do. But a new teacher took the class. Johnny took a dislike to the new man and would not even bother to fill out his exam papers. Why should he try? He believed that the teacher would fail him anyway. His insecurity made him feel that nobody liked him. And so he misbehaved — to show his masculinity, to rebel against all authority, to take revenge on his family and on society. But he was not happy and his behavior revealed it. Stealing, truancy and lying were only symptoms of his inner disturbance.[5] After uncovering Johnny's latest misdeeds — an extortion racket in which he sold back mittens to the children from whom he had stolen them — the principal was forced to expel him. With his parents' consent, he was sent to a training school for boys.

ROLE OF THE TRAINING SCHOOL

Institutions are used as the last resort for the care of the delinquent. Here, loneliness may be strengthened, hostility unleashed and detrimental learning obtained by watching other maladjusted children.[6] Most institutions attempt to screen their employees, by psychological testing, so that only mentally healthy people are helping these children. They try to arrange the boys and girls into small groups and to create a cheerful, homelike atmosphere. Usually the two sexes are kept in separate schools. The training school attempts to put the child back into his own surroundings as soon as possible and to help him once he is back. In 1950, the International

Union of Child Welfare stated:

> After-care must consist of positive action to help the individual understand his problems, accept his responsibilities, and find a solution to his difficulties. It must not be merely an occasional and authoritarian supervision or a rigid and routine system of control.[7]

A DIFFICULT RETURN

Four months later, Johnny came back to his class at the local high school. He still sits in the back of the classroom, alone. He is on licence and subject to return to reform school should he misbehave. He is trying to keep out of trouble. The other boys are no longer afraid to jeer "dirty Injun" when he passes — but he takes it all. He is still alone, but he is trying. He went to a school dance, and looked quite handsome in his clean shirt and trousers. He sat in a chair at the side of the auditorium all evening. No one talked to him. So tension is mounting in Johnny. When and how will it be relieved?

Johnny cannot be expected to change his life pattern in four short months. The training school stopped short of its goal. It did not help him in his readjustment to society, nor did it relieve his home pressures. In addition, it placed him in a school designed to prepare students for university — not for a trade. His average mark at the end of the first semester was 35 per cent. But he caused no trouble.

AND THE FUTURE?

A problem faces this small town — how to help Johnny. Can the public health nurse or social worker help the parents recognize Johnny's needs and their responsibility in meeting them? Would men's service clubs be willing to help? Will the police learn to relinquish the concept of punishment and substitute one of help?

The teachers can give Johnny extra instruction, or transfer him to a school offering trade courses. The churches can cooperate, too; so can other individuals within the community. People can smile and say hello when they meet him. They can instruct their children to befriend him — not to drive him into desperate action. Many months or even years may pass before Johnny will change — but with help he will. By saving him, the town will have earned for itself a trustworthy, productive citizen rather than an individual dedicated to crime.

The town must act now to save Johnny; it should have acted sooner. Throughout his childhood, Johnny was revealing his torments and problems for all to see. This was when he required understanding and guidance. Now he must learn to love again — a difficult task for one whose frame of reference is distrust and hate.

SUMMARY

Deliquency is a product of many factors — mostly environmental. In Johnny's case, there was a background of family dissension and racial prejudice. There were organizations that could have helped — the church, the school, and welfare groups. They tried — but not hard enough. Right now, there is another boy or a girl like Johnny who is about to cause trouble and who is in need of help. What are *we* doing to help this child?

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To generalize is to be an idiot — WILLIAM BLAKE

IN A CAPSULE

RECTAL TEMPERATURES

Perforations of the rectal wall may occur in infants as a result of rectal temperature taking. When tissues are friable, rectal temperature should be taken with a bulbous-tipped thermometer inserted just beyond the sphincter. Unnecessary rectal temperature taking in small infants as a routine nursing procedure should be avoided. — Canby, John P. Rectal Perforation. A Hazard of Rectal Temperatures. *Clinical Pediatrics*, 2: 223, May 1963.

VACCINE VS LEUKEMIA?

Is it possible for the human body to resist leukemia? Can such resistance be increased? A research project being conducted at the Ontario Cancer Institute in Toronto, is attempting to answer these questions.

The investigators found that splenic lumps developed in mice ten days after they had been injected intravenously with leukemic cells. Each lump turned out to be a family of leukemic cells, numbering over a million — all of which had developed from a single cell. The significance of this finding is that now the behavior of individual leukemic cells can be observed after they have been counted and injected. The effectiveness of any particular treatment in strengthening the animal's immunity can easily be tested.

Using this new technique for measuring the growth of leukemic cells in the body, the researchers have shown that mice receiving a leukemia virus six days prior to the injection of leukemic cells, resist the growth of these cells. That is, the virus behaves like a vaccine that strengthens the immunity of the animal against leukemic cells. — Can a Vaccine Prevent Leukemia? *Health*, 31: 18, June 1963.

THE EXECUTIVE AND NEUROSIS

Executives are prone to overwork, have a need to achieve and a need to compete. The dynamics responsible for this pattern were also the dynamics of the breakdown in 16 executives with neurosis. Overcompensation for inferiority feelings, often originating in low socioeconomic childhood background, and ambivalence to the father with repression of hostility were prominent, the main ego mechanisms of defence being repression and denial. The patients often attempted to turn psychotherapy into discussions and had difficulty in accepting a non-directive approach. — Forster, W. The Executive and Neurosis. *C.M.A.J.*, 88: 1244, June 22, 1963.

NEW EDUCATIONAL CONCEPT

A recent study, undertaken by the Canadian Foundation for Educational Development, concerns the relatively new concept of operating universities on a 12-month basis.

Official predictions made by the Canadian Universities Foundation, show that college enrolment across the nation will more than double in the next seven years — from 150,000 students to 312,000 in 1970-71. Yet university building programs, planned or underway, are not sufficient to accommodate anything approaching this number. An answer to this problem lies in placing some institutions on year-round operation, enabling them to take in at least one-third more students without increasing their physical facilities.

The study notes that the idea of year-round operation has sometimes run into opposition due to misunderstandings about how it operates. It does *not* mean that the staff must teach all year, though many volunteer to do so as it gives them a one-third increase in salary. It does *not* mean that all students must study all year, though many do so, as it enables them to earn their degree one year earlier than the regular system. It *does* mean more room for more students, an increasing number taking graduate work and greater economy of operation. —Webb, David C. *Year-Round Operation of Universities and Colleges*, 1963.

TWINS

JUDITH MACKAY

As viewed by a member of the "in-group."

Twins, who form about two per cent of the general population, find it necessary to struggle for identity, to demand individual recognition from a world that thinks of them as one rather than as two. Each time some thoughtless outsider asks, "which one are you ?" he strikes a blow against the twins' struggle, each to be his own man.

Twin Relationship

The relationship between twins differs from ordinary sibling relationships. At times, they will be utterly dependent upon each other and so close that one can literally experience the pleasure or pain that the other feels; the next moment they will be nursing hostile feelings toward each other — perhaps because of some jealous quarrel. They may even make an issue about the sequence of their names since twins — more than other brothers and sisters — must establish prerogatives for themselves.

While other children during their first few years develop strong emotional ties to their mothers, twins from the beginning develop strong ties to each other as well. They are thus faced with a double task. When conflicts arise between love and hate in each of their major relationships, they must strive for a balance of feeling. Let mother scold one twin and the other may feel naughty, too; when mother enters the room, both twins will go to her; if one of the twins falls and hurts himself, the other may also feel pain. Yet, despite this close attunement, the twins are rivals. They are, in fact, more acute rivals than are other brothers and sisters. Moreover, the rivalry starts at an earlier age than it does with other siblings.

Often the bond between twins is too strong; it tends to weaken the relationship to their parents. The bewilderment of parents when confronted with two identical children, whom *they* can scarcely tell apart, often makes their attitude towards the twins less warm and spontaneous. Twins need help in balancing emotional attachment to their fellow twin and to their parents. This can be accomplished only if parents will spend time with each twin by himself and will, in every sense, give him the feeling that he is a person in his own right. And a person in his own right he is.

The Struggle for Identity

There is scientific proof that even identical twins (who are more alike than any other two human beings) are not carbon copies of each other. It is true that they both develop from *one* ovum that has been fertilized by a single sperm. At some early stage of development, the single fertilized egg splits in half to form two individuals who are always of the same sex. These two are so much of one flesh that skin or kidney can be transplanted from one to the other. However, they are not precisely the same in all hereditary qualities. They are apt to begin life at different sizes and grow at different rates. They have different aptitudes, talents, interests and skills. Moreover, their first environment, the uterus, is not precisely the same for each. One will inevitably take advantage of the other in position and in making use of the mother's prenatal food supply.

Two-thirds of all twins are fraternal resulting from the fertilization of two separate eggs, each by a separate male

Miss MacKay and her twin sister are student nurses at the Kitchener-Waterloo Hospital, Kitchener, Ont.

cell. These are two entirely different individuals who, through exceptional circumstances, were born together. They may be of the same or of different sex. They differ in their hereditary make-up and may be utterly unlike each other.

Many reliable studies show, however, that fraternal as well as identical twins share a more common environment than other children — an environment so similar that it is bound to increase their natural resemblance. Other studies show that identical twins enjoy similar reputations, are likely to find themselves in the same classroom, have similar health records and in many other respects, share a more common physical and social environment than that ordinarily experienced by fraternal twins. These studies show that on the average identical twins are much more similar in intelligence than are fraternal twins. If, for instance, one of a pair of identical twins is mentally retarded, the other usually is also (91 per cent of the time); in the case of fraternal twins, there is only a 47 per cent similarity in retardation.

Environment is influential in shaping each twin's personality.

Identical twin sisters — one of whom was raised on a farm, the other in a city — showed sharp differences in personality: The farm girl grew up to be rugged, energetic and adventuresome; the city girl grew up to be delicate, placid and more feminine in appearance and behavior.

It has been said that no man having a twin brother has ever become famous. There is no apparent reason why a twin should not become famous, but it does seem to be true. The names of famous "only children" come readily; the names of famous twins are hard to find.

Twins persist in using infantilisms for a longer period than most children. They also tend to trail well behind other children in speech — both in articulation and in vocabulary. The only area of speech development in which they do have the edge on other children is in their gift for dramatic play. Usually, when they start school, they catch up quickly. Parents can help them in the preschool period by getting them to spend a fair proportion of their time both with adults and with other children who speak well.

Twins and Siblings

Parents of twins sometimes wonder what effect the twins will have on other children in the family. An elder child will have very much the same reaction of jealousy when his mother has twins as he would have if only one baby were born. His reaction may be heightened when special attention is paid by relatives and friends to the arrival of two individuals.

A child who has twins as elder brothers or sisters is likely to feel that it is quite natural that there are two children of the same age in the family. He will eventually begin to observe the extra attention the twins command and to realize that they are, in some mysterious way, more of a team than are other children. Twins always have each other as companions; they are seldom alone and they make an intimate pair. This intimacy that excludes other brothers and sisters will be the most tormenting aspect to the younger child who, although a brother or sister, seems to be an outsider. This outsider is likely to build a pretend world for himself, to invent imaginary companions, and to find great compensation in a heightened fantasy life of his own.

As they grow older, twins must be encouraged to make friends within their own peer group even though it is not always easy to find a place in a group for two who go as a couple. Unless they have been encouraged early to break emotionally free of each other and to transfer some of the love they feel for each other to their parents, they will have difficulty in courtship and marriage. No man and no woman wants to marry two. Twins are two separate people.

Parents can encourage individuality by: dressing the twins in different outfits; selecting Christmas and birthday gifts that are unlike; encouraging individual talents and skills; referring to them by name rather than as "the twins."

Rivalry can be minimized by avoiding competition between them; by refraining from drawing comparisons; by discouraging others from making com-

ments such as "which one are you ?"

Twins are individuals and should be treated as such. The possibility of emotional problems arising in later life will be minimized if parents remember and apply this approach.

Jennifer Learns About Diabetes

SANDRA YOUNG

Jennifer, 16 years old, was a new diabetic. Her condition was discovered following her collapse in school. When the initial shock was over, she became very interested in learning all that she could about this strange "newcomer" in her life — diabetes mellitus.

Jennifer's family physician had discussed the facts concerning diabetes briefly with her. However, he noted that she seemed somewhat confused with so much new knowledge, and he thought that it would be advisable if the nurses started at the beginning again. He wanted her to learn all that she would need to know about diabetes in order to care for herself and to lead a normal life. He also asked that her family — mother, father, 20-year-old brother and 14-year-old sister — should be included in the teaching plan.

Jennifer apparently had not fully understood her doctor's attempt to familiarize her with diabetes since her first reactions upon learning that she would have to take certain necessary precautions for the remainder of her life were fear and bewilderment. The teaching plan for Jennifer began with an explanation of the physiology of diabetes. She found a biology course that she had been studying very helpful in understanding endocrine function and the failure of the pancreas, in her own case, to produce insulin.

She asked many questions about her symptoms and the reasons behind them. The body's attempts to rid itself of excess sugar through the kidneys with resultant polyuria, dehydration and excessive thirst provided an explanation for several of her queries. She mentioned particularly her constant, unsatisfied hunger, and her loss of weight. With help, she worked out her own solution to the fate of the excess calories. Jennifer vividly remembered other symptoms that she had experienced previous to her collapse, and now we helped her to piece them together as typical of ensuing diabetic coma.

This seemed a good time to point out to Jennifer that she was not alone in her distress. According to statistics, approximately one out of every 100 Canadians is a diabetic, although 40 percent are not aware that they have the condition. She was amazed to hear that she had something in common with a greatly admired tennis player, Tony Trabert, for Jennifer, too, loved to play the game. She was surprised to find that, although her diabetic condition was more severe than that associated with older age, with care she could lead as normal a life as any other teenager.

Although interested in learning about diabetes, Jennifer was somewhat depressed as she began to realize

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Miss Young was a second year student at St. Joseph's Hospital School of Nursing in Victoria, B.C., when this study was prepared. She was a first prize winner in the 1962 Macmillan Award Competition in comprehensive nursing care studies.

what her "new life" would mean. At her next lesson, she had an opportunity to talk to Mrs. White, who was also a diabetic. She had accidentally nicked her toe while cutting her toenails, and the sore that developed required hospital care to heal. Seeing someone else with the same condition who was alive and reasonably well, and encouraged by Mrs. White's leadership and guidance Jennifer began to regain her self-confidence.

She learned that there were several types of insulin available for diabetes; her doctor decided that N.P.H. was the most suitable one for her. She was taught what to expect if she ever developed insulin shock, as well as the common remedies. Naturally, at this stage, she was not aware that symptoms such as lightheadedness, increased pulse, nervousness, and profuse perspiration were warnings of the body's need for sugar. Shock could come about for one or more of three reasons: too much insulin; inadequate food intake; too much exercise in comparison to caloric and insulin intake. Jennifer was urged to carry two sugar cubes with her at all times, or be within reach of orange or other fruit juice. These forms of carbohydrate are easily and rapidly absorbed into the blood stream and should raise the blood sugar level sufficiently to counteract insulin shock. If these remedies were not satisfactory, Jennifer was taught that soda crackers and milk would give more prolonged effect until other food could be taken and the situation remedied.

Jennifer, like most new diabetics, worried about the exacting balance to be kept between diet, insulin and exercise. She was afraid that she would never be able to learn the various diet exchanges well enough to eat away from home; that she would have trouble giving herself those "dreaded" needles; that she would never again be able to swim, or play tennis. In reassuring Jennifer, Mrs. White proved once again the value of experience. Without her encouragement, Jennifer would have been very much inclined to cast the whole burden of fear onto her mother.

After several visits from the dietitian Jennifer discovered that her diet was just as varied and interesting as that of any normal person. She began to lose her fear that preparation of her meals would be a burden to her mother. She knew that it would be very difficult to refuse her mother's delicious desserts but the problem was easier to overcome because she had such a variety of good food to choose from. She began to plan for the many adventures she could have in calculating her calories, and trying out new and exotic foods. She even thought of the advantage that a "sweetless" diet would have for her teenage figure.

Her meal planning for the day included a fairly small breakfast, either a large lunch or a moderate one and a mid-afternoon snack, a moderately large dinner, and a small snack at bedtime. The teaching program for Jennifer began to show good results. She was able to explain the reasons for her diet and meal arrangements. She recalled that her N.P.H. insulin started its action *immediately,* but its *peak* action occurred six to ten hours after the injection. As a result she would need greater food intake at that time to balance its action. Since N.P.H. acts for 24 to 30 hours, the moderate dinner and bedtime snack were necessary to carry her through the night. With breakfast, again preceded by the daily injection of insulin, the cycle would continue in balance with daily exercise.

The necessity for good health was impressed on Jennifer since infection can upset the whole balance of diet, insulin and exercise for the diabetic. Jennifer, herself, brought out one of the many reasons for this as she explained her own inability to eat if she had even a cold or flu. The danger here is understandable. Insulin shock is inevitable unless the balance of diet and insulin can be restored. Jennifer also learned that bacteria thrive in a sugar-rich bloodstream, which is shown by the high incidence of complications through infection in diabetes. There appears to be greater bacterial resistance due to rapid multiplication, thus the slightest infection is serious for a diabetic.

The importance of good foot care was impressed on Jennifer by Mrs. White. She explained the value of cut-

ting her toenails to prevent them becoming in-grown; drying her feet thoroughly after soaking them; applying alcohol and talcum powder; wearing properly fitted shoes. All of these measures help to prevent infection and, in particular, gangrene which seems much more prevalent in diabetics. Mrs. White advised Jennifer to do simple exercises to maintain good circulation in her legs; elevate the legs for a short period, sit with the feet hanging for a few minutes, and finally lie supine for a short time.

One lesson was spent in reminding Jennifer of the importance of urine testing. She had had some practice, using the hospital equipment, but she found the task quite unpleasant. A reminder that a positive urine test could be an early warning signal made her resolve to try harder to learn the proper technique and readings. She was told that there were several methods of testing urine for sugar and acetone but she found the hospital method quick and simple, and the use of inexpensive Clinitest units at home appealed to her. It was suggested to her that the doctor might also ask her to do a daily urine test to regulate her amount of exercise. Since she knew that this would help to decide whether or not she could take part in sports — especially her favorites, tennis and swimming — her enthusiasm for urine testing increased.

By this time Jennifer's parents, brother and sister, had been given booklets to read and additional information concerning diabetes. Many of their fears were overcome as a result, and they proved interested and willing to learn what they could do to help. With the usual wisdom of parents, her mother and father realized that much of the burden of relieving Jennifer's inevitable frustrations, and helping her to realize the joys of a teenager would fall on their shoulders.

Jennifer's next lesson was spent in conquering her fear of injection. Brenda, her young sister, had asked with a mixture of wide-eyed fear and excitement, to be present — and so she was. The remainder of the family had agreed that each one would like to have the same opportunity. It was arranged that they could attend an injection to learn the procedure.

At this important lesson, Jennifer was shown the various types of syringes made especially for insulin injection: 40 units per cc.; 80 units per cc.; over 80 units per cc. Jennifer had been in the hospital long enough to realize that her equipment would have to be sterilized in some way. She was very surprised to find that it could be done so simply with proper use of some of her mother's utensils. Having collected the household strainer, a saucepan, alcohol and absorbent cotton, she was eager to try her hand at "playing nurse." Using a needle and syringe that she had sterilized herself, she cleansed the bottle top with an alcohol sponge, injected the needle and withdrew the solution, after she had rotated the vial between her hands to mix the insulin, Brenda, too, eventually mastered the technique — after contaminating several needles and breaking a syringe — but such difficulties were overlooked because in their enthusiasm to learn, both girls lost their fear of the procedure.

Jennifer had been quick to notice that the nurses never used the same spot twice in succession for injection, but it was still a surprise to find that there were so many places on her body where injections could be given. Now she learned why varying the sites helped to assure good absorption since the formation of lumps beneath the skin (induration) was prevented. Both Jennifer and Brenda enjoyed mapping injection areas on their legs and arms. Suitable sites on other areas of their bodies were discussed as well.

The actual step of injection was the moment that both had dreaded, but somehow they managed to live through it, using me as their guinea pig. Their nervousness with the equipment brought back vivid memories of the first time I had attempted the same procedure: holding the arm, while I attempted to control the syringe, maintain the desired 45° angle, avoid contaminating the needle, and above all, overcome that fear of piercing flesh which is always associated with pain for someone else. Jennifer and Brenda were permitted to practise one injection on each other using sterile physiological saline as their solution. Then

Jennifer agreed to try to give her own insulin the following morning. Brenda was anxious to try her hand at giving the actual dosage of insulin, but she realized that Jennifer needed repeated experience and that there would be other opportunities for her to practise. The entire family attended the final lesson in order to review any procedure desired, and to ask any questions that might have been bothering them. The main topic of discussion concerned a trip which they had thought it would be impossible to take. Everyone was reassured to learn that, with some planning and by avoiding "mixture" foods, eating in restaurants or diners would not be a particular problem for Jennifer. Mrs. Stephens had already been planning menus and was pleasantly surprised to find that the plain foods required included most fruits, vegetables, meats, fish and poultry, milk, butter and bread, bacon, eggs, cheese and other foods that Jennifer had enjoyed previously. The family was already familiar with the commercial insulin kits; they knew that insulin did not necessarily have to be refrigerated and they were further relieved to learn that the insulin injections would follow the normal pattern. The injection would not attract any undue attention even if it proved necessary to give it while parked on a crowded street. It was suggested that urine testing should be done often, even more frequently than at home, for this would certainly provide the way of knowing if Jennifer's condition was remaining in control. The results could mean the difference between telephoning a local doctor for advice, or having to rush Jennifer to a local hospital for emergency treatment of diabetic coma or insulin shock.

This same discussion presented an opportunity to remind Jennifer that she should carry an identification card with her at all times. This card outlines the procedure to be followed in case of insulin reaction, as well as the owner's customary diet and insulin dosage. Finally, Jennifer and her family were told about the local Diabetic Association. This organization sends out new information concerning diabetes to its members and provides a meeting place for them to come together and discuss any problem in daily living. It has met a need for many diabetics who have felt alone and overwhelmed by their difficulties.

Jennifer was scheduled to leave the hospital two days after this final meeting. She was relieved and yet very fearful of what the future held. Perhaps it was just those "butterflies" that caused her nausea, for she had eaten her full allowance of lunch, but she vomitted the meal shortly after eating. She did not report this and as a result, both her nurses and Jennifer were very surprised to find her in her room at 2:30 p.m. with a very rapid pulse, perspiring profusely, hands trembling, unable to answer questions directly enough to explain what was happening. Her symptoms indicated insulin shock and she was given a glass of orange juice, followed shortly after by a glass of milk and two soda crackers. After her dinner, Jennifer was once again feeling her normal self, and explained what had happened. She had not felt it necessary to report the emesis because she had actually eaten the food and she saw no danger. Besides, she did not want to bother the "busy nurses" with such a trivial matter. This experience of Jennifer's formed an unscheduled part of her teaching plan. She finally agreed that it had been a beneficial experience. Now she knew about insulin shock and, most important, the warning symptoms.

Both Jennifer and her family had progressed well in their attempt to deal with this new problem in their lives. Jennifer had been an apt pupil, and it was evident that her family would be a great help to her as she faced her future. A deep friendship had developed between Mrs. White and Jennifer. The young girl knew that Mrs. White would always be ready and willing to share her experiences as a diabetic, through any trials that might arise.

Life's too short for chess. — HENRY J. BYRON

FRONTIERS IN MEDICINE

MARY ANN WICKHAM

There are an estimated 15,000 crippled children in Ontario who are innocent victims of accidents, disease and tragedies of chance.

"That's a funny name to call it. There are no crippled children here!" These solemn words from the lips of a resident child at the Ontario Crippled Children's Centre in Toronto tell the true story of the feelings of many handicapped children. This little boy obviously understood "crippled" as being totally helpless, but the children around him who were learning to walk, talk, propel themselves in wheelchairs and coordinate their bodies for more effective living did not fit into this classification.

In-patient facilities for children who require long-term, round-the-clock care have been at a premium in Ontario. Similarly, out-patient services for youngsters in heavily populated Metropolitan Toronto and the surrounding area have been inadequate. This shortage of specially designed treament facilities has hampered study, diagnosis and treatment.

As early as 1945, the Ontario Society for Crippled Children was aware of these problems. Over the years, as it helped many unfortunate youngsters by providing them with medical advice and attention, nursing care, equipment, camping services, financial assistance and a host of auxiliary services, the need for a well-equipped treatment centre became increasingly obvious. Through its special campaign committee the Society raised the necessary funds to provide such a centre; the doors opened early in 1962. Its aim is to prepare handicapped children to achieve the maximum degree of self-help that their physical, mental and emotional beings allow.

Miss Wickham is director of nursing services at the Ontario Crippled Children's Centre, Toronto, Ontario.

The Centre covers 11 acres in north-eastern Toronto. There are sufficient wooded areas to provide an ideal playground for the children, including an Indian village.

Children from all over the province are directed to the Centre through medical referral from their doctors. Applications are received, reviewed and plans for admission made for those who are likely to benefit from the program.

After admission preliminaries, the parents and child are interviewed by a social worker who tells them about the program. The parents are assured that they will be informed about the child's progress and given help in preparing for his return home. A visit to the hospital wing, which accommodates 105 children, follows. The four wings of the hospital divide the children into age and sex groups. At this time the parents and child are interviewed by a member of the medical staff and a preliminary physical examination is carried out. The proposed program for the child is explained and arrangements made for him to be seen by specialists.

The child and his parents are introduced to the supervising staff and to the nurse who has a major position on the rehabilitation team. Her discussion with the parents gives her some insight into the existing parent-child relationship and helps her establish rapport with the family. The nurse plays an important part in encouraging the child to develop his individual capacities, and in persuading the parents to foster this independence. Finally, the child is taken to his own unit which is in the appropriate area for his age group. The nurse introduces him to the other children who will

soon become his "room-mates."

After the child has been examined by the psychiatrist a definite program is established. The physiotherapist works with him for the prescribed length of time. The nurse cooperates by maintaining the therapy program on the ward. The occupational therapist trains the child in specific areas that help him to develop new levels of manual dexterity. Speech and swallowing difficulties and the development of acceptable speech patterns are dealt with by the speech therapist. Dental care is also provided for those with problems of this nature.

Education is not neglected. The child may enrol in the Centre school in the same grade that he was in at home. A play therapy department provides care and recreation for the children who must remain in bed. The play therapist supplements work of the physiotherapist by providing an opportunity for the child to practise new skills through "fun." Another member of the team is the church nurse who provides spiritual guidance and counselling for children who may feel overwhelmed by their handicap and who are experiencing difficulty in acceptance.

A comprehensive recreational program has been planned for the children during their free hours: movies, outside excursions, play in the gardens provided by the Garden Club of Toronto. The gardens provide a choice in swings, sandboxes, doll houses, trading post, tree house, stockade, tepees that make up the Indian Village or one of many other outside games.

The nurse must remember that the child does not need pity or sympathy. Children, as a rule, are oblivious of the significance of these emotions until adults show them the "advantages" to be gained by demanding them. The child needs understanding and the knowledge that others will accept his differences and accord him status as an equal.

When the child has shown progress in his program he may return home permanently or until further treatment is indicated. Before doing so, his parents usually spend two or three days at the Centre, visiting each department and becoming familiar with his routine. Accommodation is available in the Parent Lodge provided by the Rotary Club of Toronto.

After a busy day a little deaf girl with cerebral palsy bustled down the hall pushing her small friend in a wheelchair. They stopped to talk to *their* nurse who was going off duty. "I can't walk and she can't hear, so she is my legs and I'm her ears" was the proud statement as they said "goodnight until tomorrow."

Chuckle

During the closing minutes of the Canadian Medical Association Council, some members of Ontario and Quebec delegations, appreciating the threat to personal freedom inherent in some of the resolutions that had been passed during the previous two days, presented resolutions to the effect that:

WHEREAS Council had considered smoking in relation to lung cancer and passed resolutions making it inadvisable for doctors to smoke, and

WHEREAS Council had considered tightening laws against drinking drivers and passed resolutions making it indvisable for doctors to drink;

Therefore be it resolved that C.M.A. Council never discuss sex.

— *Ontario Medical Review*

Stand By for Life

A busy advertising executive and an automobile accident are the key ingredients in this dramatic new motion picture in color and sound designed for showing to community groups.

The film, produced for the Ontario Hospital Association, emphasizes the increasing scope and quality of hospital care and its vital relationship to the community. It shows the problems of the patient and those of the hospital — problems that are intriguingly and sometimes even amusingly intertwined.

This 26-minute film is available for showing from the Ontario Hospital Association, Flemington Park, Don Mills, Ontario.

* * *

Wisdom denotes the pursuing of the best means. — FRANCIS HUTCHESON

About Books

The Hormones in Human Reproduction by George W. Corner. 281 pages. McClelland & Stewart Ltd., Toronto. 1963.

The substance of this pocketbook was presented by the author at the Vanuxem Lectures, Princeton University, in 1942 to an audience of laymen. It is written, therefore, with the assumption that the readers lack familiarity with biology.

The Art of the Case Study. 36 pages. Macmillan & Co., Ltd., London. 1962.

This booklet consists of eight outstanding patient care studies reprinted from the British journal *Nursing Times,* and an introduction on "How to Write a Case Study."

Pharmacology Applied to Patient Care by Lucy F. Hoblitzelle, R.N., M.A. 204 pages. F.A. Davis Co., Philadelphia. Ed. 2. 1963.

This manual is divided into two parts: The mathematics of drug administration and the study of drugs. Each chapter contains basic information followed by a "questions for study" page which the student can complete for herself.

In combination with a pharmacology textbook, this manual should be a useful teaching aid.

Examination Review for Practical Nurses by Arlene Speelman, R.N., M.S. 328 pages. G. P. Putnam's Sons, New York. 1962.

The objective of this book is to help provide the graduate practical nurse with experience in writing a "one best answer" type of examination question.

Review questions and answer sheets are provided for topics such as personal hygiene, growth and development, nutrition and diet therapy, nursing arts, anatomy and physiology, medical-surgical nursing, pharmacology and others.

Drugs and Pharmacology for Nurses by S.J. Hopkins, F.P.S. 264 pages. E. & S. Livingstone Ltd., London. 1963.

This text is designed to provide nurses with a basic knowledge of pharmacology, and a survey of drugs in current use. Its value in Canada would be limited due to the differences in proprietary names of many drugs.

Handbook for Nursing Aides. 333 pages. The Hospitals and Charities Commission, Victoria, Australia. 1961.

Prepared for the young lady training as a nursing aide, this text covers such topics as hygiene, bedside nursing care, special nursing care, nutrition, care of children and of the aged, etc. It is well illustrated.

Materia Medica for Nurses by W. Gordon Sears, M.D., M.R.C.P. 294 pages. Edward Arnold Ltd., London. 1962.

The author prepared this text with the belief that nurses need a comprehensive text that links up drugs and therapeutics with physiology.

The frontispiece states that this handbook is "recognized as a standard textbook in the English-speaking world." This is obviously not true, since this book would have limited use in Canada due to the differences in proprietary names of many drugs.

Toward Quality in Nursing. 73 pages. U.S. Dept. of Health, Education, and Welfare, Washington. D.C. 1963.

The report of the "Surgeon General's Consultant Group on Nursing" (U.S.A.) is presented in this manual. Part one reports on needs and goals; part two discusses ways of moving toward these goals.

Aids to Ear, Nose and Throat Nursing by Susanna Marshall, S.R.N. 256 pages. Baillière, Tindall and Cox, London. Ed. 3. 1962.

This is another of the "Nurses Aids Series" pocketbooks designed to provide "concisely, clearly and simply just that quantity of information which the nurse needs to possess . . ."

In this new edition, chapters on congenital deformities and diseases of the mouth have been omitted along with out-dated procedures. Their place has been taken by new operations and developments. Emphasis throughout seems to be on disease and treatment rather than on nursing care.

In Memoriam

(Continued from page 963)

Nellie Grace (Fitch) French (Regina General Hospital '34) died earlier this year in Winnipeg.

* * *

The alumnae association of The Children's Hospital, Winnipeg, pays tribute to the memory of the following graduates: **Inez (Sylvester) Jones** '25 and **Marguerite (Inkster) McDonald** '26.

* * *

M. I. Jeanne d'Arc Lapointe (St. Mary's School of Nursing, Timmins, Ont. '58) died as the result of an automobile accident on June 16, 1963. She was 25 years old.

* * *

The alumnae association of The Montreal General Hospital pays tribute to the memory of: **Marguerite E. MacLeod** '26 and **Olive V. Mulligan** '25.

* * *

The alumnae association of the Lady Stanley Institute, Ottawa, pays tribute to the memory of **Anna Margaret McNiece** '05 and **Luella (McEwan) Wood** '21.

* * *

S. Amelia (Perry) Milne (Grace Hospital, Toronto '16) died in May 1963.

* * *

Katherine (Johnson) Mundie (Chipman Memorial Hospital, St. Stephen, N.B. '16) died in April 1963 after a long illness.

* * *

Jennie Ida Paul (Nicholls Hospital, Peterborough '25) died on May 14, 1963.

* * *

The alumnae association of Vancouver General Hospital pays tribute to the memory of: **Helmin Hamilton Rice** '13 and **Maud Rodena Ward** '17.

* * *

Marie Jeanne Gabrielle Christine Roy (University of Ottawa '59) died as the result of an accident in Toronto on April 20, 1963. Miss Roy was completing postgraduate work in nursing education at the time of her death.

* * *

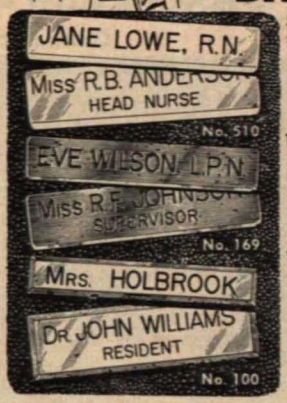
Margaret Helen (McBoyle) Sahl (General Hospital, Moose Jaw '49) died in Moose Jaw on May 16, 1963. She was a former staff member of Mossbank Union Hospital, Saskatchewan.

* * *

Kathleen (Wiggett) Shephard (Western Division, The Montreal General Hospital '13) died in May 1963.

Reeves

UNIFORM BADGES



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Christine Alice Sutherland (Aberdeen Hospital, New Glasgow, N.S. '21) died recently in Millbrook, N.S. She was on the staff of Robert Brigham Hospital, Roxbury, Mass., for 30 years and, at the time of her retirement in 1962, held the position of superintendent of nurses.

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Registered Nurses for modern 70-bed General Hospital. $300 to $345/m. Certified Nursing Aides $200 to $230, 40-hr. wk., liberal policies, yearly increments, residence available. Situated in prosperous Peace River Country. Apply: Sister Superior, Sacred Heart Hospital, McLennan, Alberta. 1-62-1

Registered Nurses for 18-bed, 8-bassinet hospital in fastest growing community of Northern Alberta. Salary $345-$375. New nurses' residence available. Apply to: Miss S. Grant, Matron, Municipal Hospital, Manning, Alberta. 1-59-1

Registered Nurses for busy 44-bed active treatment hospital. Salary: $325 per mo. with bi-yearly increments. Excellent accommodation in recently opened nurses' residence. Medical and Hospitalization Group Plans. Liberal Holiday and sick schedule. Apply: Holy Cross Hospital, Box 339, Spirit River, Alberta. 1-81-1

Registered Nurses (Immediately) for 54-bed hospital. Basic salary $300/m with 3 annual increments to $345, increment adjusted to previous experience. Group medical, hospitalization and pension plans. 40-hr. wk., 31 days' vacation after one year, accommodation in residence $35. Apply: Director of Nursing, Municipal Hospital, Vermilion, Alberta. 1-90-2

Registered Nurses (6) for new 50-bed Auxiliary Hospital, situated on main C.N.R. line, 128-mi. from Edmonton. Salary according to AARN schedule with yearly increments, 40-hr. wk. Apply to: Matron, Wainwright-Provost Auxiliary Hospital District No. 21, Box 481, Wainwright, Alberta. 1-94-1A

Registered Nurses for General Duty (O.R. training helpful) for 40-bed hospital, 70-mi. south of Calgary, centre of wheat growing area. Salary as per AARN schedule, board and room $20, Group Insurance and Pension, 3-wk. vacation plus 9 statutory holidays. Separate residence. Will consider all applicants even if further inducement required. Town offers swimming pool, golf, curling, paved highway, nearby ranches, proximity of National Parks and cities. Apply in writting to: Director of Nursing, Municipal Hospital, Box 299, Vulcan, Alberta. 1-93-1

General Duty Nurses for well-equipped 76-bed hospital in active town of 3,000. Salary $300-$350 for Alberta registered; $290-$340 for non-Alberta registered. New separate residence, excellent personnel policies & working conditions. Apply to: Director of Nursing, Brooks General Hospital, Brooks, Alberta. 1-13-1

General Duty Nurses. Starting salary: $300 per mo., 40 hr. work wk. Room, board & laundry available, if desired, at nominal rates. Civil Service holiday, sick leave & pension benefits. Apply to: Baker Memorial Sanatorium, Dept. of Public Health, Calgary, Alberta. 1-14-3

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Information on these and other positions is available from Medical Services Directorate, Department of National Health and Welfare, in Vancouver, Edmonton, Regina, Winnipeg, Ottawa and Quebec, or from the

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General Duty Nurses (2 immediately) for modern 25-bed hospital on Highway No. 12. Salary range $320 to $365 depending upon qualifications and experience. New staff residence. Full maintenance $35, personnel policies include Blue Cross, M.S.I. and pension plans. 21 days' vacation per year, plus statutory holidays. Apply to the: Director of Nurses, Municipal Hospital, Coronation, Alberta. 1-25-1

GENERAL DUTY NURSES for 243-bed hospital (1958). Salary $300-$345, excellent personnel policies, pension plan, medical and hospital benefits available. Apply: Director of Nursing, Medicine Hat General Hospital, MEDICINE HAT, ALBERTA. 1-64-1A

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NURSES fully qualified for 30-bed active treatment hospital. New hospital building and recently renovated nurses' residence. Unless definitely interested in coming, please do not apply. Personnel policies sent upon request. Apply to: Mrs. M. Hislop, Superintendent, Municipal Hospital, Bassano, Alberta. 1-5-1

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DIRECTOR OF NURSING for 50-bed active acute hospital, preparation in nursing administration preferred. Experience in nursing administration essential. Salary open, position open January 1st, 1964. Qualifications for registration in B.C. required. Apply giving full particulars to: Administrator, Kimberley and District Hospital, Kimberley, British Columbia. 2-35-1

Psychiatric Unit: Nurses, preferably with P.G., for small, new unit in General Hospital. Services coordinated with new mental health clinic. Apply: Director of Nursing, General Hospital, Kelowna, British Columbia. 2-34-1

Head Nurse, male or female, for active Operating Room Unit. Postgraduate training required. Good personnel policies; residence accommodation available (female). Apply to: Director of Nursing, Trail-Tadanac Hospital, Trail, British Columbia. 2-72-1

OPERATING ROOM — HEAD NURSE for 434-bed active General Hospital with school of nursing, only 15 miles from Vancouver, B.C. Apply to: Director of Nursing, ROYAL COLUMBIAN HOSPITAL, NEW WESTMINSTER, BRITISH COLUMBIA. 2-73-13B

MATRON for 31-bed hospital. Salary $400/m with annual increments. 3-room furnished suite and board $33. Hospital fully staffed. B.C. registration required. Previous experience as Matron not necessary but applicants must have supervisory ability. Enquiries to: Chairman, Ocean Falls Hospital Board, Ocean Falls, British Columbia. 2-49-1

General Duty and O.R. Nurses with postgraduate course or equivalent experience required for 146-bed General Hospital. Personnel policies in accordance with RNABC. Apply: Director of Nursing, General Hospital, Chilliwack, British Columbia. 2-13-1

General Duty Nurses for active 30-bed hospital. RNABC policies and schedules in effect also Northern allowance. Accommodations available in residence. Apply: Director of Nursing, General Hospital, Fort Nelson, British Columbia. 2-23-1

General Duty Nurses for 110-bed hospital in northwestern B.C. Salary—B.C. registered $335-$402, non-registered $320. Newly furnished residence with T.V. Good social activities, including bowling, curling, tennis and year-round swimming. Full personnel benefits including travel allowance. Apply to: Director of Nursing, General Hospital, Prince Rupert, British Columbia. 2-58-2

General Duty Nurses for well-equipped 80-bed General Hospital in beautiful inland valley adjacent Lake Kathlyn and Hudson Bay Glacier. Initial salary $335, maintenance $50, 40-hr. 5-day wk., 4-wk vacation. Boating, fishing, swimming, golfing, curling, skating, skiing. Comfortable nurses' residence, rail fare advanced if necessary. Apply: Sacred Heart Hospital, Smithers, British Columbia. 2-73-13

General Duty, Operating Room & Experienced Obstetrical Nurses for 434-bed hospital with school of nursing. Salary: $320-$387. Credit for past experience & postgraduate training. 40-hr. wk. Statutory holidays. Annual increments; cumulative sick leave; pension plan; 28-days annual vacation; B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia. 2-73-13

Graduate Nurses and Certified Nursing Assistants for 70-bed acute General Hospital on Pacific Coast. Salary for B.C. registered $320 with regular increments; unregistered $305; Nursing Assistants $214-$246. Board and room $25 per mo., 28-day vacation plus 10 statutory holidays after 1 year. Superannuation and medical plans. Apply: Director of Nursing, St. George's Hospital, Alert Bay, British Columbia. 2-2-1

General Duty Nurses (2); Certified Nursing Aide (1) for 45-bed hospital. RNABC policies in effect. Friendly city with many social activities — fishing, boating, swimming, golfing, curling, skating and skiing. Apply: Director of Nursing Services, Fernie, British Columbia. 2-22-1

Graduate Nurses and Certified Nurse Aides for 75-bed hospital opened September 1962. Salary: B.C. Reg. Nurse 1963, $320 - $387. Salary: Non Reg. Nurse 1963, $305. Certified Nurses Aides, $200 - $221 RNABC personnel policies in effect. Very active town in Cariboo ranching country. Apply: Director of Nursing, Cariboo Memorial Hospital, Williams Lake, British Columbia. 2-80-1

Graduate Nurses for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic rate $320/m with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia. 2-9-1

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Graduate Nurses for General Duty in medicine, surgery, obstetrics, pediatrics and operating room in new, modern 160-bed hospital in city (20,000) on east coast of Vancouver Island. Personnel policies in accordance with RNABC policies. Starting salary for R.N. — $320/m. Apply to: Director of Nursing, Regional General Hospital, Nanaimo, British Columbia. 2-46-1

Graduate Nurses for General Duty (2 or 3) for small hospital in southern B.C. after Sept. 1. Salary $320/m, room, board and laundry $40, 10 paid statutory holidays and 28 days' vacation after one year. Superannuation and sick leave benefits. Excellent working conditions and ample recreational facilities such as swimming, skiing, curling, etc. in area. Apply, giving full particulars to: Adminstrator, Slocan Community Hospital, New Denver, British Columbia. 2-48-1

Operating Room, Obstetrical and General Duty Nurses, British Columbia registered, for modern 450-bed acute General Hospital, located on South Vancouver Island. Basic salary $320, credit for experience & postgraduate preparation, personnel policies in accordance with RNABC. For particulars write to: Director of Nursing Service,St. Joseph's Hospital, Victoria, British Columbia. 2-76-5

Nurses two for 30-bed hospital. Salaries as per B.C. Registered Nurses' agreement. Comfortable nurses' home. Apply to: Miss H. Campbell, R.N., Director of Nursing. Community Hospital, Grand Forks, British Columbia. 2-27-1

MANITOBA

Registered Nurses (2) for 42-bed hospital located 38-mi. from Winnipeg. 1963 salary schedule $325 - $370/m, 3 annual $15 increments. Credit given for experience. 40-hr. wk., complete maintenance $45/m in modern nurses' residence. Usual holidays and sick leave benefits. For further information and application forms write to: Miss Josephine Giesbrecht, R.N., Director of Nursing, Bethesda Hospital, Steinbach, Manitoba. 3-59-1

Registered Nurses and Licensed Practical Nurses (immediately) for 700-bed General Hospital. Positions available on medical and surgical wards, maternity, nursery, O.R., pediatrics and psychiatry. Salary in accordance with qualifications and experience. Differential salary for evenings and nights, liberal personnel policies. For further information contact: Miss J. Robertson, R.N., Director of Nursing Service, St. Boniface General Hospital, St. Boniface, Manitoba. 3-74-1

Registered and Practical Nurses (immediately) for 18-bed hospital at Vita, Man., 70-mi. from Winnipeg. Starting salary, R.N. $330 - L.P.N. $225, with allowance for experience. Daily bus service. 40-hr. wk., full maintenance available for $50/m. Apply to: Matron, District Hospital, Vita, Manitoba. 3-68-1

General Duty Registered Nurses for 62-bed General Hospital situated in a progressive community in western Manitoba. Building project in planning stage. Salary $310-$360 from January 1, 1963. Residence accommodation available. For further particulars please contact: Miss E. R. Shacklady, Director of Nurses, Swan River Hospital, Swan River, Manitoba. 3-62-1

Nurses for active 35-bed hospital. A few R.N.'s or L.P.N's. Salary range R.N. $310-$345; L.P.N. $220-$260. Hospital does not have residence but will arrange for room close to hospital. Apply to: Sister Superior, Sacred Heart Hospital, Russell, Manitoba. 3-50-1

NORTHWEST TERRITORIES

DIRECTOR OF NURSING SERVICE: Applications are invited for the position of Director of Nursing at the 44-bed Stanton Yellowknife Hospital. This prosperous mining community in Canada's exciting Northland offers a wide variety of sports and activities for your fun and pleasure. There is a suite available in the nurses' residence, with all modern conveniences. Descriptive literature and personnel policies supplied on request. Apply stating qualifications and supervisory experience, to: Administrator, Stanton Yellowknife Hospital, Box 10, Yellowknife, N.W.T. 12-11-1

General Duty Nurses (2) for active 44-bed hospital located in Canada's exciting northland. AARN rates plus northern allowances and liberal fringe benefits in effect. Modern residential conveniences available. Apply to: Director of Nursing, Stanton Yellowknife Hospital, Box 10, Yellowknife, NWT. 12-11-1

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General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia. 6-21-1

Operating Room Nurse, Nova Scotia registered, immediately for 43-bed hospital in the beautiful Annapolis Valley. Apply to: Director of Nursing, Western Kings Memorial Hospital, Berwick, Nova Scotia. 6-7-1

ONTARIO

Supervisor — Hospital, Head Nurse, Registered Nurses and Registered Nursing Assistants for 150-bed hospital. Salary scales as applicable in Ontario. All conventional benefits available. Apply giving details of training and experience to: The Director of Nursing. The Cottage Hospital, Pembroke, Ontario. 7-98-1

Registered Nurses for 34-bed hospital, min. salary $340, 3-wk. vacation with pay, sick leave after 6-mo. service. **All staff** — 5-day 40-hr. wk., 9 statutory holidays, pension plan & other benefits. Apply to: Superintendent, Englehart & District Hospital, Englehart, Ontario. 7-40-1

REGISTERED NURSES for modern 52-bed General Hospital (Staff Nurses immediately) Situated in skil-resort village in Georgian Bay area. Starting salary $300/m. Many employee benefits, 4-wk. vacation after 2 yrs. Opportunities for learning new skills, new experiences in hospital nursing, especially for graduates of large schools. Apply in writing or in person to the Superintendent, Centre Grey General Hospital, Markdale, Ontario. 7-76-1

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Registered Nurses, Certified Nursing Assistants (IMMEDIATELY) for 40-bed hospital in pleasant town of 5,000. 42-hr. wk. with good rotation shifts, providing long weekends every 4 wks. Good salaries and personnel policies. For further details and application, apply: Administrator, General Hospital, Espanola, Ontario. 7-41-1

Registered Nurses and Certified Nursing Assistants for 160-bed accredited hospital. Starting salary $340 and $235 respectively with regular annual increments for both. Excellent personnel policies. Residence accommodation available. Assistance with transportation can be arranged. Apply to: Director of Nursing, Kirkland & District Hospital, Kirkland Lake, Ontario. 7-67-1

Registered Nurses and Certified Nursing Assistants for immediate and future vacancies in this 42-bed hospital. Starting salaries $335 and $225, respectively. Accommodation in new residence available. Usual fringe benefits. For full information, apply to: Director of Nursing, New Liskeard and District Hospital, New Liskeard, Ontario. 7-83-1

Registered Nurses and Certified Nursing Assistants for 26-bed hospital. R.N. minimum salary $340, maximum $380, 28-day vacation after 1-yr. C.N.A. minimum salary $244, maximum $275, good personnel policies, 2-wk. vacation after 1-yr., 3-wk. after 2 yrs. Credit for past experience, $5.00 increment every 6 mo., 40-hr. wk. 8 statutory holidays. Room & board $45 per mo., 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario. 7-87-1

Registered Nurses and Registered Nursing Assistants for 60-bed hospital. Excellent personnel policies includes 5-day wk., 8 statutory holidays and pension plan. The town has a fine quarry for your swimming pleasure and Stratford's Shakespearian Festival is only a few miles away. Apply: Superintendent, Memorial Hospital, St. Marys, Ontario. 7-112-1

Registered Nurses for General Duty in well-equipped 28-bed hospital, located in growing gold mining and tourist area, north of Kenora, Ontario. Modern residence with individual rooms; room, board and uniform laundry only $45. 40-hr. wk., no split shift, cumulative sick time, 8 statutory holidays and 28 day paid vacation after one year. Salary range $350 - $375. Apply to: Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario. 7-29-1

Registered Nurses for General Duty in all departments including premature and new-born nursery, Isolation, Emergency, Recovery Room, and Intensive Care Unit. Good salary and personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario. 7-73-10

Registered Nurses for General Duty & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 80,000 people. **Salary: $325 per mo.** with annual merit increments, plus **annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply: Director of Nursing, Memorial Hospital, **Sudbury,** Ontario. 7-127-4

Registered or Graduate Nurses for modern 100-bed hospital located in summer resort district, 40-mi. from Ottawa. Apply: Director of Nursing, Public Hospital, Smiths Falls, Ontario 7-120-2

GENERAL DUTY REGISTERED NURSES for 200-bed hospital situated in a beautiful residential town on the shores of Lake Temiskaming. Starting salary $340, good personnel policies including 40-hr. wk., O.H.A. pension plan, etc. Accommodation available in residence if desired. For particulars apply to: Director of Nursing, Misericordia Hospital, Haileybury, Ontario. 7-54-1

General Duty Nurses for an accredited 66-bed hospital. Starting salary: $325. Excellent personnel policies, pension plan, residence accommodation only 10 min. from downtown Buffalo. Apply: Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario. 7-45-1

General Duty Nurses for new 70-bed hospital in Muskoka District. Starting salary $305/m., good personnel policies. Apply: Director of Nursing, Huntsville District Memorial Hospital, Huntsville, Ontario. 7-59-1

General Duty Nurses for modern 100-bed hospital. Registered Nurses $315-$345 per mo., Graduates $250-$295; 40-hr. wk., benefits include accident, sickness and life insurance, hospital and medical insurance plans, & OHA Pension Plan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario. 7-69-1

General Duty Nurses for 100-bed modern hospital, southwestern Ontario, 32 mi. from London. Salary commensurate with experience & ability; $315 basic salary. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital, Tillsonburg, Ontario. 7-131-1

General Duty Nurses Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach and great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General and Marine Hospital, Collingwood, Ontario. 7-31-1

General Duty Nurses & Certified Nursing Assistants for new 50-bed hospital with modern equipment. 40-hr. wk., 8 statutory holidays, excellent personnel policies & opportunity for advancement. Tourist town on Georgian Bay. Good bus connections to Toronto. Apply to: Director of Nurses, General Hospital, Meaford, Ontario. 7-79-1

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, ear, eye, nose and throat and orthopedic surgery. Good salary and personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario. 7-73-10A

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Public Health Nurses (qualified) Salary $3,800 - $4,800. Car allowance, employer shared pension plan and other benefits. Apply to: Mr. Allan F. Stewart, Secretary-Treasurer, Wentworth County Health Unit, Court House, Hamilton, Ontario. 7-55-14

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Public Health Nurses (Qualified) for generalized program with City of Peterborough. Salary range: $3,950-$4,700. Personnel policy available on request. Apply to: J. R. Anderson ,M.D., D.P.H., Medical Officer of Health, City Hall, Peterborough, Ontario. 7-101-3

Public Health Nurses (qualified) for generalized nursing service. Salary range: $3,800-$4,750 based on experience. Apply to: Dr. J. M. McGarry, M.O.H. St-Catharines-Lincoln Health Unit, St. Catharines, Ontario. 7-111-4

STAFF NURSES and O.R. and OBSTETRIC NURSES for 220-bed accredited hospital with School of Nursing. 1963 salary scale $305-$345. Postgraduate premium $320-$360. Usual personnel benefits, plus proximity to Ottawa, Montreal and Northern New York State. Apply: Acting Director of Nursing Service, Cornwall General Hospital, Cornwall, Ontario. 7-34-1

Staff Nurses for all nursing units of a 325-bed, fully accredited General Hospital located in downtown area. Orientation and in-service program. Rotating hours of duty. Attractive salary & fringe benefits. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario. 7-133-9

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Assistant Head Nurses and Certified Nursing Assistants for 60-bed children's orthopedic hospital. Excellent personnel policies. Apply: Miss Flora M. Lamont, Reg.N., Administrator, Shriners Hospital for Crippled Children, 1529 Cedar Avenue, Montreal 25, Quebec. 9-47-42

Matron (Must be bilingual) for 29-bed, fully accredited hospital. Starting salary commensurate with experience. Fringe benefits. Excellent living conditions and recreational facilities. Apply to: Dr. H. S. Hooper, Director of Medical Services, Grand'Mère General Hospital, Grand'Mère, Quebec. 9-25-2

Registered Nurses and Certified Nursing Assistants for modern 55-bed General Hospital, salary $320/m, 3 annual increases, 40-hr. wk., 4-wk. vacation. **Certified N.A.** starting salary $220, 3-wk. vacation, accommodation available in new motel-style residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec. 9-52-1A

Registered Nurse for General Duty (11:30 P.M. - 7:00 A.M.) in small Obstetrical unit of an accredited hospital. Basic salary $320 plus night differential and credit for experience. Living accommodation available in motel type residence with out-door swimming pool. Apply: Director of Nursing, Barrie Memorial Hospital, Ormstown, Quebec. 9-52-1B

Registered Nurses for General Floor Duty and Supervisory positions, also Nursing Assistants, for 110-bed hospital for tuberculosis and other chest diseases. Situated in the heart of the Laurentian Mountains, 55-mi. north of Montreal. Good recreational facilities. Salary in accordance with the Association of Nurses of the Province of Quebec recommendations, with full maintenance, including private room in modern nurses' residence. 40-hr. wk., 8 statutory holidays and 4-wk. annual vacation. Apply: P.O. Box 1000, Ste Agathe des Monts, Quebec. 9-57-1

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Registered Nurses (2) for 10-bed hospital. SRNA recommendations accepted. Please state qualifications. Accommodations and board $34.50/m. Apply in writing to: R. Lyle Craven, Sec.-Manager, Union Hospital, Beechy, Saskatchewan. Duties to commence as soon as arrangements are made. 10-5-1

Registered Nurses (immediately) for 85-bed General Hospital in the City of Lloydminster on the Sask. — Alta. border. Bus and train service east and west. Modern nurses' residence. Personnel policies upon request. Phone or write to: The Superintendent of Nurses, Lloydminster Hospital, Lloydminster, Saskatchewan. 10-72-1

General Duty Nurse (as soon as possible) for 9-bed hospital. Salary as per SRNA schedule, with increments. Full maintenance $35. New fully modern separate residence with TV. Apply to: Secretary, Union Hospital, Maryfield, Saskatchewan. 10-79-1

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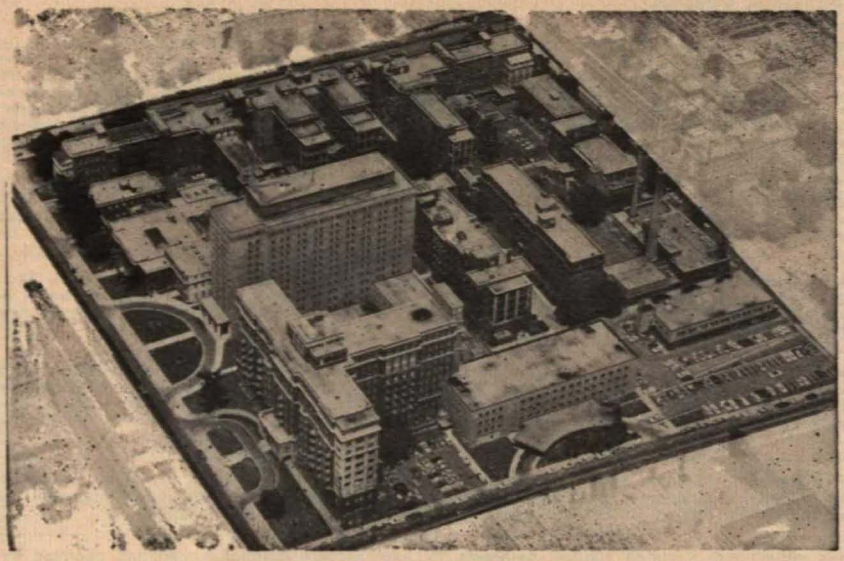

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Registered Nurses for modern 374-bed General Hospital on the beautiful, warm Peninsula yet only 20-min. from the heart of cosmopolitan San Francisco. Openings in all nursing services including operating room, emergency room, and I.C.U. Excellent personnel policies, many extra benefits and opportunities for advancement. Telephone collect, OXford 7-4061 or write: Director of Personnel, Peninsula Hospital, 1783 El Camino Real, Burlingame, California. 15-5-20

Registered Nurses. Career satisfaction, interest and professional growth unlimited in modern, JCAH accredited 254-bed hospital. Located in one of California's finest areas, recreational, educational and cultural advantages are yours as well as wonderful year-round climate. If this combination is what you're looking for, contact us now! Staff Nurse entrance salary $395 with automatic increases to $455 per mo., supervisory positions at increased rate. Special area and liberal shift differentials paid. Excellent benefits including Blue Cross hospitalization and surgical coverage and liberal personnel policies. Professional staff appointments available in all clinical areas to those eligible for California licensure. Write today: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California. 15-5-12

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Starting salary $375 per mo. plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California. 15-5-39

Registered Nurses, Staff Nurses for permanent positions, various departments, days, eves., nights. Excellent starting salary, increments, benefits and working conditions in one of the largest and finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California. 15-5-3G

Registered Nurses for private 258-bed hospital for men, women and children. Staff Nurse salaries from $380-$450, differentials for evenings, nights, communicable disease, operating room and delivery. Opportunities in all clinical areas. Holidays, vacations, sick leaves and health insurance. California registration required. Applications and details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California. 15-5-4

Registered Nurses for 233-bed modern hospital. Positions available — all services, no shift rotation. Liberal benefits, advancement opportunities, educational opportunities in area, equal opportunity employer. Apply: Director of Nursing Service, Kaiser Foundation Hospitals, San Francisco 15, California. 15-5-7

Registered Nurses and Certified Nursing Assistants for new, modern hospital owned and operated by the Daughters of Charity, located in the heart of Santa Clara Valley, 1 hr. from San Francisco, close to beaches and mountains. Needed immediately, Nurses for all tours of duty in all services, particularly O.B. and O.R. Excellent geographical location, climate, working environment contribute to your job satisfaction. Apply: Director of Nursing Service, O'Connor Hospital, San Jose, California. 15-5-10

GENERAL DUTY STAFF NURSES — Central California large General Hospital. Start $413/m. Excellent in-service education programs; liberal personnel policies, shift differential. Apply: Personnel Director, San Joaquin County, Room 530, Courthouse, Stockton, California. 15-5-36

Attention! General Duty Nurses 297-bed fully accredited County Hospital located 2-hr. drive from San Francisco, ocean beaches & mountains resorts in modern & progressive city of 35,000. 40-hr. 5-day wk., pd. vacation, pd. holidays, pd. sick leave, retirement plan, social security & insurance plan. Accommodations in nurses' home, meals at reasonable rates, uniforms laundered without charge. Starting salary $395 per mo., plus shift and service differentials. Merit increases to $458/m. Must be eligible for California registration. Write: Director fo Nursing, Stanislaus County Hospital, 830 Scenic Drive, Modesto, California. 15-5-42

Staff Duty positions (Nurses) in private 428-bed hospital. Liberal personnel policies and salary. Differential for evening and night duty. Write: Personnel Director, Hospital of The Good Samaritan, 1212 Shatto Street, Los Angeles 17, California. 15-5-38

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon and night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California. 15-5-3C

Nurses for new 75-bed General Hospital. Resort area. Ideal climate. On beautiful Pacific ocean. Apply to: Director of Nurses, South Coast Community Hospital, South Laguna, California. 15-5-50

General Duty Nurses for various departments including surgery for 72-bed hospital. Starting salary $375 per mo. with periodic increases and fringe benefits. College town, tourist area, ideal climate. Contact: Superintendent, Alamosa Community Hospital, Alamosa, Colorado. 15-6-1

Executive Director generalized public health nursing agency. Potential for program expansion in rapidly growing community 45 minutes from NYC. Staff 8 full time, 5 relief nurses. Master's degree, administrative ability; experience required, salary open. Send résumé to Mr. Charles H. Ulrich, Chairman, Personnel Committee, Visiting Nurse Association, 60 Guernsey Street, Stamford, Connecticut. 15-7-4

General Duty Nurses for 54-bed hospital, minimum starting salary $350 per mo., located near Miami and West Palm Beach. Apply: Director of Nurses, Belle Glade Memorial Hospital, Belle Glade, Florida. 15-10-3

REGISTERED NURSES: for 75-bed, air-conditioned hospital, growing community. Starting salary $330-$365/m, fringe benefits, vacation, sick leave, holidays, life insurance, hospitalization, 1 meal furnished. Write: Administrator, Hendry General Hospital, Clewiston, Florida. 15-10-1

Registered Nurse, sunny Florida, close to the Palm Beaches, South east side of Lake Okeechobee, housing available. Contact: Everglades Memorial Hospital, 1749 East Main Street, Pahokee, Florida, or call 924-5502, Director of Nurses, or Administrator, COLLECT. 15-10-4

Staff Nurses (All Areas) Orientation and staff development programs, "nurse-saving" equipment, challenging working environment, individualized living accommodations in new air-conditioned cottages. Opportunity to participate in nursing practice of the finest quality in our 200-bed General Hospital, located along Lake Michigan shoreline, 30 mi. from Chicago. Starting salaries $390-$410 plus $30 differential for 3-11 and 11-7. Write: Director of Nursing, Highland Park Hospital, Highland Park, Illinois, for detailed brochure. 15-14-3

SOUTH PEEL HOSPITAL, COOKSVILLE

HEAD NURSES AND GENERAL DUTY STAFF NURSES

required for

All departments of a new 450-bed General Hospital situated just 7 miles west of Metropolitan Toronto.

Salaries paid in accordance with the Toronto Schedule.

Many fringe benefits, including portable pensions.

Additional salary allowances for postgraduate qualifications.

For information or application, write to:

DIRECTOR OF NURSING,

South Peel Hospital, Cooksville, Ontario.

QUEENSWAY GENERAL HOSPITAL

has opportunities for male and female

REGISTERED NURSES

to

expand your professional training and skill in our modern P.P.C. accredited hospital where your nursing capabilities may be used to the fullest in a harmonious and congenial environment.

For further information write to:

THE DIRECTOR OF NURSING,
QUEENSWAY GENERAL HOSPITAL,
Sherway Drive, Toronto 18, Ontario.

DIRECTOR OF NURSING

Bilingual, required for 110-bed, fully accredited Hospital, specializing in the active treatment of and research in Tuberculosis and other Chest Diseases. Situated 55 miles north of Montreal, in the heart of the Laurentian Mountains.

Modern and comfortable suite accommodation, 40-hour week, one month vacation with pay, excellent personnel policy with conventional benefits. Salary open to discussion, pending experience and qualifications.

Please apply to:

THE EXECUTIVE DIRECTOR,
P.O. Box 1000,
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Staff Nurses and Licensed Practical Nurses (Openings in several areas, all shifts). Minimum starting pay $77 R.N.'s; L.P.N.'s $61 per wk., experience considered, differentials paid for reliefs, nights. Every other weekend off in small community hospital 2 miles from Boston. Living quarters available. Contact: Miss Elizabeth B. Kennedy, R.N., Director of Nursing, Chelsea Memorial Hospital, Chelsea, Mass. 15-22-1

Staff Nurses 380-bed hosp. new 120 med-surg. unit. Trans. pd. 1st class air to Albuq. and return within U.S. in exchange for 1-yr. emp. contract. Come to New Mexico "Land of Enchantment." Career opportunities, largest pvt. JCAH accredited hosp. in state; near U. of New Mexico, R.N. & B.S. pgm. Practical Nurse pgm. accredited state & NAPNE. Vacancies, Med-Surg. & occasionally O.B., Peds., & O.R., salaries $315 per mo. even., night or O.R. with call; 6-mo. increases up to $375; days $300 per mo. with increases up to $360. Rotation from day duty is required only when no person desiring permanent P.M. of night tour is available. Liberal personnel policies include: optional Blue Cross, Discount Hosp. Services, pd. sick leave cumulative to 5 wks., annual physical exam., vacation 1 yr. – 2 wks., 2 yrs. – 3 wks., 5 yrs. – 4 wks. Active in-service pgm. Occasional vacancy hosp. owned apts. New Mexico licensure as professional nurse & U.S. Citizenship (or Immigration Visa) required. Write or call collect: Mrs. Emily J. Tuttle, Dir. of Nursing, Presbyterian Hospital Center, 1012 Gold, S.E., Albuquerque, New Mexico. Phone 243-5611. 15-32-3

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric and pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th Street, Cleveland 6, Ohio. 15-36-1D

Staff Nurses for modern 400-bed tuberculosis hospital, suburban Cleveland, Ohio. Monthly salaries start at $396 with semi-annual increments. Extra for night and relief duty, 5-day work wk., 3-wk. paid vacation, 6 paid holidays, liberal sick leave, comfortable accommodations in nurses' residence at low rate. Learn and earn at a progressive accredited hospital in a growing community. Write: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio. 15-36-1E

Registered Nurse (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary starts at $387. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon. 15-38-1

Staff Nurses (All Clinical Services) Base salary $350, opportunities for advancement, differential for 3-11 & 11-7 shifts, personnel policies, sick leave, retirement plan, 3-wk. vacation & laundry of uniforms. Orientation & in-service programs, housing available on campus. Apply: Director of Nursing Service, University of Texas Medical Branch Hospitals, Galveston, Texas. 15-44-5

Staff Nurses — University Hospital wants you if you want a challenging and rewarding position in a modern expanding 320-bed teaching and research hospital located on campus. Salary $380-$444/m. Opportunities in clinical research, premature center, chronic renal program, open heart surgery, and physical medicine, in addition to the general services. Liberal benefits including tuition free courses after six months. Contact: University Hospital, 1959 Pacific Avenue, Seattle, Washington. 15-48-2D

MISCELLANEOUS

Supervisor: Applications are invited to fill a vacancy pending. Salary dependant upon qualifications and experience. 40-hr. wk. Good personnel policies. Residence accommodation available. Apply to: The Director of Nursing, The Queen Elizabeth Hospital, 130 Dunn Avenue, Toronto 3, Ontario. 7-133-32

Registered Nurses for general duty in 14-bed modern newly built hospital. Salary: $320-$345 per mo. 40-hr. wk., 3-wk. vacation. Usual fringe benefits. Apply to: Miss F. Bourgeois, Hornepayne Community Hospital, Box 190, Hornepayne, Ontario. 7-134-1

Registered Nurses for northern 36-bed hospital. Standard SRNA conditions plus isolation bonus, plus transportation from Prince Albert or Saskatoon. Write to: Rev. Father L. Poirier, o.m.i., Administrator, St. Joseph's Hospital, Ile-a-la-Crosse, Saskatchewan. 10-48-1

General Duty Staff Nurses for 450-bed, fully approved hospital. Salary range per mo: Day Duty, $438-$458. P.M. and night duty, $448-$468. 40-hr. wk. Paid vacation. 7 paid holidays per yr. Accumulative sick time based on length of service. Liberal hospitalization plan. Nurses' residence. Rooms at reasonable rates. Registration or permit to work in California required. Address applications to: Chief Nurse, Southern Pacific Railroad Hospital, San Francisco, California. 15-5-6B

Registered Nurses (Immediately) for 93-bed General, short term Hospital. Fully accredited. Excellent salary and liberal fringe benefits. Playground of Pacific Northwest. Apply to: Director of Nurses, Olympic Memorial Hospital, Port Angeles, Washington. 15-48-5

NURSES

KENORA, ONTARIO

This resort town of 14,000 people has just opened a section of its new 100-bed hospital and in the not too distant future will be opening the second section for which nurses are needed. The hospital is wonderfully located on the shores of beautiful Lake of the Woods in Ontario, in the summer we have activities in swimming, boating, fishing and golfing and in the winter there is skating, curling, tobogganing, skiing and ice fishing.

A nurse's residence is available at a reasonable rate of $20 per month for private room or $15 per month for a double room. Cafeteria services are available at cost as well as a kitchen in the nurses' residence. Separate personnel policies for nurses are available and will be mailed on request. The starting salary is $315 per month. Eight statutory holidays, sick leave, three weeks vacation with pay are some of the benefits of these policies.

All applications will be treated with courtesy and privacy.

Please apply to:

Administrator

Mr. A. C. DUNCAN,
KENORA GENERAL HOSPITAL,
KENORA, ONTARIO

HAMILTON GENERAL HOSPITAL

GENERAL STAFF NURSES

required for

INTENSIVE CARE UNIT, SURGERY, MEDICINE, EMERGENCY DEPARTMENT AND OPERATING ROOMS.

For personnel policies and further information, apply to:

DIRECTOR OF NURSING
Hamilton General Hospital
Barton Street East
Hamilton, Ontario

ONTARIO SOCIETY

For

CRIPPLED CHILDREN

Requires

QUALIFIED EXPERIENCED PUBLIC HEALTH NURSES

YOU WILL RECEIVE —

- GOOD SALARY RANGE
- A NEW AUTOMOBILE
- PENSION PLAN
- FREE INSURANCE
- 3-MONTH TRAINING COURSE

You will deal directly with children, their parents and service club members. Apply to:

MISS SARA E. OLIPHANT REG.N.
SUPERVISOR OF NURSING
ONTARIO SOCIETY
FOR CRIPPLED CHILDREN
350 RUMSEY ROAD
P.O. BOX 1700, STATION "R"
TORONTO 17, ONTARIO.

MEMORIAL HOSPITAL, BOWMANVILLE

ONTARIO

Offers excellent opportunities for

REGISTERED NURSES

and

REGISTERED NURSING ASSISTANTS

In modern well-equipped 166-bed General Hospital, new wing with 116 beds opened in 1962.

Good salaries and modern separate residence accommodation, excellent personnel policies and working conditions.

For full information, apply to:

DIRECTOR OF NURSING

WANTED

Registered Nurses for hospital work in northern Newfoundland and Labrador.

The Grenfell Mission offers challenging opportunities for satisfying investment of time and service.

For details write:

MISS DOROTHY A. PLANT, Secretary,
Grenfell Labrador Medical Mission,
Room 701A, 88 Metcalfe Street,
Ottawa 4, Ontario.

REGISTERED NURSES

required

NURSE TECHNICIAN TEAM

INTRAVENOUS MEDICATION
GOOD PERSONNEL POLICES

Apply:

ASSISTANT DIRECTOR (Medical)
Ottawa Civic Hospital, Ottawa, Ontario.

BERWYN MUNICIPAL HOSPITAL

Requires Registered Nurses for General Duty — Salary $300 to $345 M.S.I.

Apply to:

DIRECTOR OF NURSING
BERWYN MUNICIPAL HOSPITAL - BERWYN, ALBERTA

PUBLIC HEALTH NURSES

REQUIRED FOR HEALTH BRANCH, B.C. CIVIL SERVICE

Positions available for qualified Public Health Nurses in various centres in British Columbia. SALARY: $375 - $462 per month; car provided. An opportunity for interesting and challenging professional service in this beautiful and fast-developing Province. For further information and application forms, apply to The Director, Public Health Nursing, Department of Health Services and Hospital Insurance, Parliament Buildings, Victoria, B.C., or to The Chairman, B.C. Civil Service Commission, 544 Michigan Street, Victoria, B.C.

COMPETITION No. 63:101

POSITIONS OPEN — REGISTERED NURSES

Starting Salary $330 per month - Allowance for experience - Enquiries invited - Personnel Policies on request - 40 Hour Week - 9 statutory Holidays - Room and Board - Nurses' Residence $45 per month
New Hospital to be completed very soon

Apply to: Mrs. G. AUGER
DIRECTOR OF NURSING, LITTLE LONG LAC HOSPITAL, GERALDTON, ONTARIO

ASSISTANT DIRECTOR OF NURSING SERVICE

Wanted for McKellar General Hospital. An active treatment hospital of 380 beds, with a progressive school of nursing. Postgraduate preparation essential; Baccalaureate Degree preferred.

APPLY TO:
Director of Nursing,
McKELLAR GENERAL HOSPITAL,
Fort William, Ontario.

THE SCARBOROUGH GENERAL HOSPITAL

A new modern hospital located 10 miles from downtown Toronto
invites applications from:

REGISTERED NURSES
REGISTERED NURSING ASSISTANTS

Opportunities are offered in Supervisory, Head Nurse and General Duty positions. Services are offered in Medicine, Surgery, Obstetrics, Pediatrics, Emergency and Intensive Care Units.

Salaries commensurate with prevailing current salaries for Nurses in Metropolitan Toronto and adjustable with experience and educational qualifications.

Progressive Personnel Policies, Pension Plan, Orientation and In-service Program.

For further information write to:

DIRECTOR OF NURSING
SCARBOROUGH GENERAL HOSPITAL, SCARBOROUGH, ONTARIO

NURSES, REGISTERED

250-Bed General Acute Hospital, Centrally located in SAN FRANCISCO, CALIFORNIA

IMMEDIATE day, evening and night positions available for nurses in:
SURGERY, CARDIAC AND INTENSIVE CARE, GENERAL STAFF DUTY

Qualified applicants guaranteed positions for visa purposes.

SALARY RANGE from $385 to $455 plus $38.50 P.M. shift (3 - 11:30 P.M.) and specialty differentials, medical benefits and liberal holiday and vacation benefits.

GRADUATE medical resident program with University of California Medical School in General Surgical, Neurological, Ortho, and Plastic Surgery.

For further information, please write to:

MISS LOIS JAHN, DIRECTOR OF NURSING,
FRANKLIN HOSPITAL,
14th and Noe Sts., San Francisco, California

REGISTERED NURSES – PLEASE NOTE

The expanding and progressive hospital and clinic services of the Mental Health Services of British Columbia need Registered Nurses and Nurses who are preparing for registration.

WE INVITE YOU TO LET US KNOW YOUR INTEREST IN:

* A MEDICAL-SURGICAL, PSYCHIATRIC, GERIATRIC OR MENTAL RETARDATION UNIT OR A COMMUNITY MENTAL HEALTH CLINIC
* A STAFF NURSE, ASSISTANT HEAD NURSE, HEAD NURSE, SUPERVISOR, INSTRUCTOR OR MENTAL HEALTH NURSE POSITION
* FULL OR PART-TIME EMPLOYMENT
* CHALLENGING WORK WITH EXCELLENT OPPORTUNITIES FOR ADVANCEMENT
* GOOD PERSONNEL POLICIES
* TEMPORARY RESIDENCE ACCOMMODATION OR WORK WITHIN COMMUTING DISTANCE FROM NEW WESTMINSTER, BURNABY OR VANCOUVER

For further information, please write:

Director of Nursing Services, Mental Health Services,
828 West Tenth Avenue,
VANCOUVER 9, BRITISH COLUMBIA.
COMPETITION No. 63:470

SCHOOL OF NURSING

METROPOLITAN GENERAL HOSPITAL

requires

INSTRUCTOR IN PSYCHIATRIC NURSING

This is an opportunity to participate in the development of a progressive program which emphasizes educational nursing experiences for the student. The program consists of 2 basic, preparatory years followed by one year of Nursing Internship. One class of 32 students is admitted annually. **Duties include:** Instruction in Introductory Psychology and Mental Hygiene. Clinical and Classroom Instruction in Psychiatric Nursing. **Requirements:** University preparation in Nursing Education. — Salary differential for Degree. — Duties to commence August, 1964.

For further information, contact:

Director, School of Nursing, 2240 Kildare Road, Windsor, Ontario

INSTRUCTORS

MEDICAL-SURGICAL NURSING

This is an opportunity to participate in the development of a progressive School of Nursing. **Student enrollment of 300 — New School of Nursing, Medical and Surgical Units just completed.**

Duties include classroom and clinical instruction in certain areas of an integrated course in Medical-Surgical Nursing.

Requirements: University preparation in Nursing Education.

Apply to:

DIRECTOR OF NURSING
St. Joseph's School of Nursing, Hamilton, Ontario

SUPERINTENDENT OF NURSES

Required by 18-bed Private Hospital. Ontario registration required.
Registered Nurse with supervisory experience or experience as Superintendent of small hospital would fill requirements. Two room apartment with bath and all meals supplied for $20 per month. Four weeks annual vacation per year, eight statutory holidays, hospitalization, medical-surgical and Group Insurance. Moving expenses up to $50 refunded following six months employment. Salary scale will be forwarded following application.

Apply to:

MRS. V. M. SWITZER, SECRETARY,
BOARD OF DIRECTORS, Lady Dunn Hospital, Wawa, Ontario.

HUMBER MEMORIAL HOSPITAL

HOSPITAL —

Newly expanded 350-bed hospital. Progressive patient care concept.

SALARY —

1963 schedule General Staff Nurses $325-$375 per month and Certified Nursing Assistants $230-255 per mo.

HOUSING —

Furnished apartments available at subsidized rates.

JOB SATISFACTION —

High quality patient care and friendly working environment, personal recognition and professional development.

You are invited to enquire concerning employment opportunities to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL

200 Church Street, Weston, Ontario - Telephone 249-8111 (Toronto)

GENERAL DUTY NURSES FOR ALL DEPARTMENTS

Gross salary $325 monthly with annual increments for 4 years to $365.

Until registration in Ontario is established — $300.

Rotating periods of duty — 40 hour week, 8 statutory holidays annually — Annual vacation 21 days after one year.

Annual sick time 12 days after one year, unused portion cumulative to 36 days.

Hospitals of Ontario Pension Plan.

Ontario Hospital Insurance and Physicians' Services Incorporated, 50% payment by hospital.

Apply:

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO

OSHAWA GENERAL HOSPITAL

Oshawa, Ontario

Requires for School of Nursing

CLINICAL INSTRUCTOR IN SURGICAL NURSING

with Certificate in Nursing Education

For further information, apply to:

DIRECTOR OF NURSING,
Oshawa General Hospital, Oshawa, Ontario.

GENERAL DUTY NURSES

SALARY RANGE $327 - $362

Required by Metropolitan Toronto for the new Riverdale Hospital, an 800-bed hospital for chronic and convalescent patients. Shift allowances for afternoon and night shifts. Cumulative sick pay and pension plans are in effect. Permanent positions, 40 hour week.

Apply:

PERSONNEL OFFICE,
387 Bloor Street East, Toronto 5, Ontario.

MONTREAL CHILDREN'S HOSPITAL

invites applications

From Graduate Registered Nurses with Psychiatric postgraduate preparation and Male Child Care Workers to fill vacancies on small 14-bed active Psychiatric Unit. Good personnel policies. Salary commensurate with experience and preparation. Active In-Service Program.

Apply in writing to:

DIRECTOR OF NURSING,
Montreal Children's Hospital, 2300 Tupper Street, Montreal 25, Que.

ASSISTANT DIRECTOR OF NURSING

REQUIRED

For a 163-bed General Hospital.

Please reply to:

Director of Nursing,
KIRKLAND AND DISTRICT HOSPITAL,
Kirkland Lake, Ontario.

ASSOCIATE DIRECTOR OF NURSING SERVICE

General Hospital of 280 beds located in a progressive and friendly city in sunny southern Alberta. Population 27,000. School of Nursing with a maximum enrollment of 90 Students. Excellent personnel policies including coverage for hospitalization, medical services and a pension plan. Salary based on education and experience.

Write to:

Director of Nursing,
MEDICINE HAT GENERAL HOSPITAL,
Medicine Hat, Alberta.

GLENROSE PROVINCIAL GENERAL HOSPITAL

requires

SUPERVISOR and STAFF NURSES

For Handicapped Children's 30-40 bed Department. Opening date approximately **November 1st, 1963.**

Also Graduate and Staff Nurses for Convalescent Units approx. 250-300 beds.

Apply in writing:

THE DIRECTOR OF NURSING SERVICE,
Glenrose Provincial General Hospital, 10230-111th Avenue,
EDMONTON, ALBERTA.

SUPERVISOR

Required for Operating Room Department, 6 theatres, 160-bed hospital. New modern hospital on Vancouver Island. Personnel policies according to RNABC.

For information, write to:

DIRECTOR OF NURSING,
NANAIMO REGIONAL GENERAL HOSPITAL,
Nanaimo, B.C.

DIRECTOR OF NURSING

Qualified Director required for 190-bed chronic hospital located in southwestern Ontario, to be fully responsible for planning and directing Nursing Service. Several years' experience in a nursing administrative capacity required, with special consideration given to applicants having rehabilitation training or experience. University degree in nursing desirable.

Attractive salary and other employee benefits available, also hospital residence accommodation, if desired.

Address all applications and enquiries to:

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PARKWOOD HOSPITAL, LONDON, ONTARIO.

GENERAL STAFF NURSE POSITIONS

AVAILABLE

in the General Operating Rooms (includes general surgery, cardiac, neurosurgery, plastic, ear, nose and throat and urology), Gynecological and Ophthalmological operating rooms. Salary commensurate with experience. Opportunities for promotion. Excellent fringe benefits including refund of tuition up to six points per semester.

For further information write:

DIRECTOR, NURSING SERVICE
THE JOHNS HOPKINS HOSPITAL
Baltimore 5, Maryland

ST. JOSEPH'S HOSPITAL

Toronto, Ontario

REGISTERED NURSES

and

CERTIFIED NURSING ASSISTANTS

600-bed fully accredited hospital provides experience in Operating Room, Recovery Room, Intensive Care Unit, Pediatrics, Orthopedics, Obstetrics, General Surgery and Medicine.

Orientation and Active In-service program for all staff.

Salary is commensurate with preparation and experience.

Benefits include Pension Plan, Group Life Insurance, Sick Leave — 12 days after one year, Ontario Hospital Insurance — 50% payment by hospital.

Rotating Periods of duty — 40 hour week, 8 statutory holidays — annual vacation 3 weeks after one year.

Apply

ASSISTANT DIRECTOR OF NURSING SERVICE
ST. JOSEPH'S HOSPITAL
30 The Queensway, Toronto 3, Ontario

YOUR INQUIRY

RE:

Opportunities for Registered Nurses at this General Medical Teaching Hospital 30 minutes from Windsor, Ontario.

IS INVITED

Please write or call:
CHIEF, NURSING SERVICE
VETERANS ADMINISTRATION HOSPITAL,
DEARBORN, MICH.

Telephone: LOgan 2-6000, EXT. 336
Excellent working conditions.
Liberal Benefits.
Minimum $5,035.

OPERATING ROOM NURSE

FOR

32 BED HOSPITAL
DEEP RIVER, ONTARIO

R.N. graduate with postgraduate course in surgery or with equivalent operating room experience.

Salary range from $3,970 - $4,630 depending upon qualifications.

Accommodation available in staff hotel.

Benefits include: Three weeks annual paid vacation accumulative sick leave. Superannuation. Hospital, Medical-Surgical Plans.

Quote file number, and include full details in first letter to:

FILE 8 A.
ATOMIC ENERGY OF CANADA LIMITED,
Chalk River, Ontario.

GRADUATE STAFF NURSES

Opportunities for men and women on all services including metabolism, rehabilitation, psychiatry, recovery room, medicine, surgery, pediatrics, obstetrics, operating room, and emergency room. Well planned orientation and in-service programs, tuition-free courses at Western Reserve University after 3 months employment, low cost housing in nurses' residence. Liberal personnel policies with premium for evening and night tours of duty. Starting rate based on experience and education. Staff nurse salary range $385 to $425. Write for more information and the booklet "New Horizons in Nursing," to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITALS OF CLEVELAND

University Circle, Cleveland 6, Ohio

MONTREAL CHILDREN'S HOSPITAL

has vacancies for

1. **Registered Nurses and Certified Nursing Assistants**
   on various wards — Bilingual preferable but not necessarily.
2. **Operating Room Nurses with either postgraduate preparation or experience.**

Apply in writing to :

Director of Nursing
MONTREAL CHILDREN'S HOSPITAL
2300 Tupper Street, Montreal 25, Que.

NURSES

If you desire to practise your profession in a modern and scientific hospital, that has 21 specialties and 1,050 beds, join the nursing staff of

NOTRE DAME HOSPITAL

Generous salaries, according to qualifications, with periodic increases. Differential for evening and night duty, 10 statutory holidays. Vacation based on date of employment. Pension plan. In-service education program. Recreational center

For information, write to:

LA DIRECTRICE DU NURSING
Hôpital Notre-Dame, 1560 est, rue Sherbrooke, Montréal 24

GRADUATE STAFF NURSES

required for

MEDICAL AND SURGICAL AREAS

University teaching hospital. Applicants should be eligible for Ontario Registration. Personnel policies and further information may be obtained from:

DIRECTOR OF NURSING,
Kingston General Hospital, Kingston, Ontario.

VICTORIA HOSPITAL

LONDON, ONTARIO

Modern 1000-bed hospital

requires

Registered Nurses for all services

and

Registered Nursing Assistants

40 hour week - Pension plan
Good salaries and Personnel Policies.

Apply:

DIRECTOR OF NURSING,
VICTORIA HOSPITAL, LONDON, ONT.

CLINICAL SUPERVISORS

1—to supervise two medical wards.

1—to supervise two surgical wards.

228-bed hospital, staffed by

Registered Nurses and Nursing Assistants

Apply to:

Director of Nursing,
JOSEPH BRANT MEMORIAL HOSPITAL,
Burlington, Ontaro.

REGISTERED NURSES

and

CERTIFIED NURSING ASSISTANTS

for

360-bed accredited General Hospital. Registered Nurses salary range $315-$355 per month with consideration for contemporary experience or special preparation.

Certified Nursing Assistants $210 - $240 per month.

For further information write:

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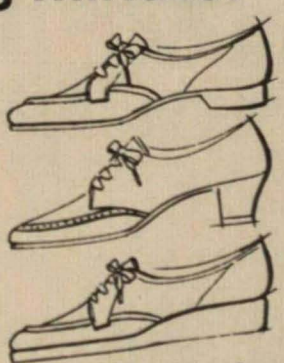

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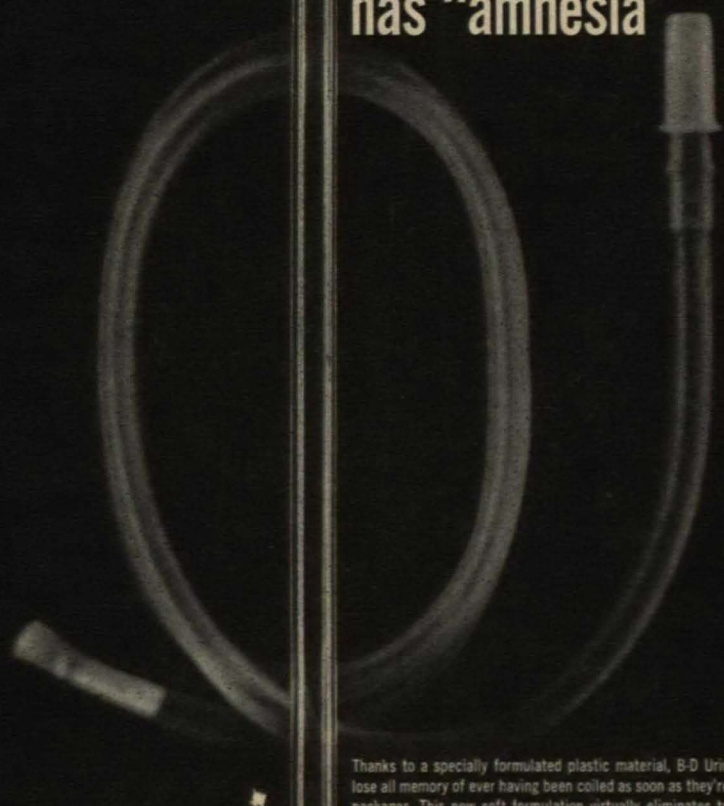

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